Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.5

Includes Changes Implemented through November 2014

Submitted by:

South Carolina Department of Health and Human Services

DRAFT

Submission Date:	

CMS Receipt Date *(CMS Use)*	

State:	
Effective Date	

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE

HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors.

State:	
Effective Date	

1. Request Information

A. The **State** of **South Carolina** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. **Program Title** (*optional – this title will be used to locate this waiver in the finder*): Palmetto Coordinated System of Care for Children (PCSC) Home and Community Based Waiver

C. **Type of Request:** *(the system will automatically populate new, amendment, or renewal)*

Requested Approval Period: (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

☒	**3 years**
☐	**5 years**

☐	**New to replace waiver** Replacing Waiver Number:		
☐	**Migration Waiver** – this is an existing approved waiver Provide the information about the original waiver being migrated		
	Base Waiver Number:		
	Amendment Number (if applicable):		
	Effective Date: (mm/dd/yy)		

D. **Type of Waiver** *(select only one)*:

☒	**Model Waiver**
☐	**Regular Waiver**

E. **Proposed Effective Date:** 1/1/2017

Approved Effective Date *(CMS Use):*

F. **Level(s) of Care**. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan *(check each that applies)*:

☐	**Hospital** *(select applicable level of care)*	
	☐	**Hospital as defined in 42 CFR §440.10** If applicable, specify whether the State additionally limits the waiver to subcategories of the

		hospital level of care:
		Psychiatric Care within a general hospital and inpatient psychiatric hospital for children/youths under age 21 as provided in 42 CFR 440.160.
	☐	**Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160**
☐	**Nursing Facility** *(select applicable level of care)*	
	☐	**Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155** If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
	☐	**Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**
☐	**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)** If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID facility level of care:	

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

☐	**Not applicable**
☒	**Applicable**

Check the applicable authority or authorities:

☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
☐	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*

Specify the §1915(b) authorities under which this program operates (*check each that applies*):

☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)

☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*
☐	**A program authorized under §1915(i) of the Act.**
☐	**A program authorized under §1915(j) of the Act.**
☐	**A program authorized under §1115 of the Act.** Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

☐	**This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The State of South Carolina (State) is developing the Palmetto Coordinated System of Care (PCSC) for South Carolina's children and youth with significant behavioral health (BH) challenges or co-occurring conditions in or at imminent risk of out-of-home placement. PCSC is an evidenced-based approach that is part of a national movement to develop family-driven and youth-guided care, and keep children at home, in school, and out of the child welfare and juvenile justice systems. The State's goal is for children and families to receive services when needed and designed to achieve safe, healthy, and functional lives as successful, responsible, and productive citizens.

The purpose of this waiver is to provide home and community-based supports and services to children with mental illness who would otherwise be served in inpatient general and psychiatric hospitals. Families and youths are offered the choice of behavioral health services and supports to permit the youths to remain in, or return to, the least restrictive environment- preferably their homes. To be eligible, a potential waiver child/youth must meet the inpatient level of care and meet all Medicaid financial requirements.

These services are provided using a system of care approach. There is a single point of entry for all waiver applicants. Applicants are evaluated to determine eligibility for the waiver. Families and youths who enter the waiver participate in person-centered plan development meetings made up of stakeholders that may currently be involved with the family and any representatives the family chooses to attend. During the meeting, a person-centered plan is developed. The family may choose from enrolled qualified providers that are composed of both public and private providers. If the family has a provider who they have been working with who is not a qualified provider, efforts are made to contact the provider to discuss their interest in enrolling. The CFT/TCM person-centered plan meets at least every 90 days to discuss treatment progress and any changes that are requested or more often as needed or requested. Annual reevaluations are conducted to determine continued eligibility for waiver participation.

The South Carolina Department of Health and Human Services (SCDHHS), as the State Medicaid agency, has both the operational and administrative authority over the waiver.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. **Appendix A** specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. **Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. **Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. **Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one)*:

☐	**Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
☒	**No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. **Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. **Appendix H** contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. **Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. **Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

☐	**Not Applicable**
☐	**No**
☐	**Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

☐	**No**
☐	**Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐	**Geographic Limitation**. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area*:
☐	**Limited Implementation of Participant-Direction**. A waiver of statewideness is requested in order to make ***participant direction of services*** as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area*:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan

and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity

and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified throughout the application and in **Appendix H**.

I. Public Input

t. Describe how the State secures public input into the development of the waiver:

SCDHHS Stakeholders from family service organizations, public child-serving agencies, private and public providers including community-based providers, and families have been involved in the development of the Palmetto Coordinated System of Care (PCSC) program from the beginning. Their participation in stakeholder sessions began in 2011 when the State received its first SAMHSA system of care grant and is ongoing. To date, SCDHHS has held over 170 meetings to discuss the goals of a program for children and to receive feedback on the benefit and system design. The workgroups that have formed over the last several years include the following: Service Array, Ongoing Family Involvement, Provider Capacity and Training, Outcome Measures, Peer Support, Building Bridges Initiative Advisory Board, Cultural and Linguistic Competency, Communications, Planning Group, Leadership Team, Interagency Planning Group and the Joint Council on Children and Adolescents. The groups met either monthly or quarterly beginning in 2013 with several continuing to meet with SCDHHS on a regular basis. A more detailed list of each workgroup, their task, composition and meeting dates is available upon request from SCDHHS.

SCDHHS held several stakeholder sessions specifically related to the 1915(c) waiver on June 6, June 8, June 13, and June 15, 2017. A live webinar was also held on June 6, 2017. The purpose of these meetings and webinar was to receive public input according to the federal requirements. The public comments have been reviewed and reflected into the final submission to CMS.

In addition to continuing to meet with the stakeholder groups, SCDHHS continues to utilize the www.scdhhs.gov website as a means to communicate with stakeholders, including children/youth, families, and provider community about the upcoming PCSC changes. SCDHHS maintains a document containing frequently asked questions on the website to respond to questions SCDHHS has received related to waiver implementation. These documents are routinely updated as new questions are received. The website location is: https://www.scdhhs.gov/service/waiver-management-field-management. As part of the public notice, SC notified the Medical Care Advisory Committee (MCAC) of the 1915(c) waiver on February 9, 2016. An update was given on May 9, 2017. Notices to all individuals on the SCDHHS listserv were sent on May 1, 2017. A copy of these notices is available through the Medicaid Agency.

SCDHHS has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit this Medicaid 1915(c) waiver request to CMS. This notice was made February 9, 2016 and an updated was given on May 9, 2017. A copy of the applicable notice is available through the Medicaid Agency.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Goodlett				
First Name:	Gwynne				
Title:	PCSC Project Director				
Agency:	South Carolina Department of Health and Human Services				
Address :	P.O. Box 8206				
Address 2:	1801 Main Street				
City:	Columbia				
State:	South Carolina				
Zip:	29201				
Phone:	803-608-5287	**Ext :**		⌙	**TTY**
Fax:					
E-mail:	gwynne.goodlettGwynne.Goodlett@scdhhs.gov				

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:				
First Name:				
Title:				
Agency:				
Address:				
Address 2:				
City:				
State:				
Zip :				
Phone:		**Ext:**	⌙	**TTY**
Fax:				
E-mail:				

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: _____

State Medicaid Director or Designee

Submission Date:	

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:	Singleton				
First Name:	Deirdra T.				
Title:	Acting Director				
Agency:	South Carolina Department of Health and Human Services				
Address:	P.O. Box 8206				
Address 2:					
City:	Columbia				
State:	SC				
Zip:	29202-8206				
Phone:	(803) 898-2580	**Ext:**		⌙	**TTY**
Fax:					
E-mail:	Deirdra.Singleton@scdhhs.gov				

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

N/A The State will implement statewide on August 1, 2017.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

N/A – The SCDHHS PCSC waiver is compliant with the new HCB setting requirements at the start of this waiver because this is a new waiver program. No transition plan is required.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver *(select one)*:

☐	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one)*:		
	☐	The Medical Assistance Unit *(specify the unit name) (Do not complete Item A-2*)	Division of Behavioral Health
	☒	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit. Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency. (*Complete item A-2-a)*	
☒	The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency. Specify the division/unit name:		
	In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (*Complete item A-2-b).*		

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities.

N/A

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

N/A

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (s*elect one)*:

☒	**Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).** Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*
☐	**No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity *(Select one)*:

○	**Not applicable**
●	**Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
	☐ **Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:*
	☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these entities and complete items A-5 and A-6*:

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

N/A

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

N/A

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	o	⌐	⌐	⌐
Waiver enrollment managed against approved limits	o	⌐	⌐	⌐
Waiver expenditures managed against approved levels	o	⌐	⌐	⌐
Level of care evaluation	o	⌐	⌐	⌐
Review of Participant service plans	o	⌐	⌐	⌐
Prior authorization of waiver services	o	⌐	⌐	⌐
Utilization management	o	⌐	⌐	⌐
Qualified provider enrollment	o	⌐	⌐	⌐
Execution of Medicaid provider agreements	o	⌐	⌐	⌐
Establishment of a statewide rate methodology	o	⌐	⌐	⌐
Rules, policies, procedures and information development governing the waiver program	o	⌐	⌐	⌐
Quality assurance and quality improvement activities	o	⌐	⌐	⌐

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- ***Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver***
- ***Equitable distribution of waiver openings in all geographic areas covered by the waiver***
- ***Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014).***

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	Number/percent of HCBS settings meeting appropriate licensure or certification requirements. **Numerator: Number of children/youths with residence and provider settings meeting requirements** **Denominator: Number of children/youths** 100% of child/youth residences through wraparound facilitator/TCM visits.
Data Source *(Select one) (Several options are listed in the on-line application): On-site, data review*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⊏ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval =*
	Other Specify:	⊏ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*	
			⌙ *Other Specify:*

Add another Data Source for this performance measure

Performance Measure:	100% of provider agencies, on-site reviews by the DHHS staff.
Data Source *(Select one) (Several options are listed in the on-line application): On-site, data review*	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⊏ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval = 95%*
	Other Specify:	⊏ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*

		⌙ *Other Specify:*		
				⌙ *Other Specify:*

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⌐ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
Other Specify:	⌐ *Annually*
	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

ii *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

b. Methods for Remediation/Fixing Individual Problems

i *Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.*

SCDHHS staff conduct performance reviews on providers to ensure that administrative functions are being carried out as required. If concerns are found with administrative functions, SCDHHS notifies the provider and requests a plan of correction. SCDHHS provides additional oversight in areas of concern until the provider has completed a plan of correction and demonstrated appropriate administrative performance.

ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*
	☐ *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☐ *Other* *Specify:*	☐ *Annually*
		☐ *Continuously and Ongoing*
		☐ *Other* *Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

☐	**No**
☐	**Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Select one Waiver Target Group	Target Group/Subgroup		Minimum Age	Maximum Age	
				Maximum Age Limit: Through age –	No Maximum Age Limit
☐	**Aged or Disabled, or Both - General**				
	☐	Aged (age 65 and older)			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☐	**Aged or Disabled, or Both - Specific Recognized Subgroups**				
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐	**Intellectual Disability or Developmental Disability, or Both**				
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Mental Retardation			☐
☐	**Mental Illness** *(check each that applies)*				
	☐	Mental Illness	18	21	☐
	☐	Serious Emotional Disturbance	0	18	

b. Additional Criteria. The State further specifies its target group(s) as follows:

Children and youth who have serious emotional disturbance (SED) or substance use disorder (SUD) challenges and who are in or at most risk of out-of-home placement are up to age 21. Together, SED and SUD are both behavioral health (BH) diagnoses. This targeting criteria includes children and youth with SUD issues only or have multi-system involvement (including foster care and juvenile justice) and meet level of care. The criteria includes children and youth with developmental disorders with co-occurring serious BH challenges, such as children and youth with autism spectrum disorders with SED or SUD. Children or youth with substance use disorder issues only are also included. The State defines transition age youth as 18-21.

Diagnoses include:

DSM-5 (ICD-10)	Diagnoses for South Carolina SED Population
Schizophrenia Spectrum and Other Psychotic Disorders	
Bipolar and Related Disorders	
Depressive Disorders	
Anxiety Disorders	
Obsessive-Compulsive and Related Disorders	
Trauma and Stressor Related Disorders	
Dissociative Disorders	
Feeding and Eating Disorders	
Elimination Disorders	
Sleep Wake Disorders	
Gender Dysphoria	
Disruptive, Impulse Control, and Conduct Disorders	
Personality Disorders	
Paraphilic Disorders	
Neurodevelopmental Disorders	
Nonpsychotic Mental Disorder, Unspecified	
Mental Disorders Complicating Pregnancy Childbirth or the Puerperium	
DSM-5 (ICD-10)	**Diagnoses for South Carolina's SUD Population and Co-Occurring SED/SUD Population**
Substance-Related and Addictive Disorders	
Caffeine-Related Disorders	
Cannabis-Related Disorders	

DSM-5 (ICD-10)	Diagnoses for South Carolina SED Population
Schizophrenia Spectrum and Other Psychotic Disorders	
Hallucinogen Related Disorders	
Other Hallucinogen Disorder (Specify the particular hallucinogen)	
292.89 Phencyclidine Intoxication	
292.89 Other Hallucinogen Intoxication	
292.89 (F16.983) Hallucinogen Persisting Perception Disorder	
292.9 (F16.99) Unspecified Phencyclidine-Related Disorder	
292.9 (F16.99) Unspecified Hallucinogen-Related Disorder	
Inhalant-Related Disorders	
Inhalant Use Disorder	
292.89 Inhalant Intoxication	
292.9 (F18.99) Unspecified Inhalant-Related Disorder	
Opioid-Related Disorders	
Opioid Use Disorder	
292.89 Opioid Intoxication	
Without perceptual disturbances	
With perceptual disturbances	
292.0 (F11.23) Opioid Withdrawal	
292.9 (F11.99) Unspecified Opioid-Related Disorder	
Sedative-, Hypnotic-, or Anxiolytic-Related Disorders	
Sedative, Hypnotic, or Anxiolytic Use Disorder	
292.89 Sedative, Hypnotic, or Anxiolytic Intoxication	
292.0 Sedative, Hypnotic, or Anxiolytic Withdrawal	
292.9 (F13.99) Unspecified Sedative-, Hypnotic-, or Anxiolytic Disorder	
Stimulant-Related Disorders	
Stimulant Use Disorder	
292.89 Stimulant Intoxication	
292.0 Stimulant Withdrawal	
292.9 Unspecified Stimulate Related Disorder	
Tobacco-Related Disorders	
Tobacco Use Disorders	
Other (or Unknown) Substance-Related Disorders	
Other (or Unknown) Substance Use Disorder	
292.89 Other (or Unknown) Substance Use Intoxication	
292.0 (F19.239) Other (or Unknown) Substance Withdrawal	
292.9 (F19.99) Unspecified Other or Unknown Substance-Related Disorder	
Non-Substance-Related Disorders	
312.31(F63.0) Gambling Disorder	

DSM-5 (ICD-10)	Diagnoses for South Carolina - Other Populations
Abuse and Neglect - Child Maltreatment and Neglect Problems	
Child Physical Abuse Confirmed	
Child Physical Abuse, Suspected	
Other Circumstances related to Child Physical Abuse	
Child Sexual Abuse Confirmed	
Child Sexual Abuse, Suspected	
Other Circumstances related to Child Sexual Abuse	
Child Neglect, Confirmed	
Child Neglect, Suspected	
Other Circumstances related to Child Neglect	
Child Psychological Abuse, Confirmed	
Child Psychological Abuse, Suspected	
Other Circumstances related to Child Psychological Abuse	

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one)*:

☒	Not applicable. There is no maximum age limit
☐	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit. *Specify*:

Six months prior to the youth reaching age 21, the family is given information regarding the transition planning procedures. A high-fidelity wraparound facilitator/TCM is available to meet with the family to discuss the transition process. SCDHHS provides families with information about other State Plan services that might be available to waiver youth upon their discharge. SCDHHS and the CFT/TCM works with the family to ensure that they are aware of and have access to available services that they can utilize to support them upon discharge from the waiver. SCDHHS staff and the wraparound facilitator/TCM are responsible for tracking when a waiver child/youth reaches age 21 and the wraparound facilitator/TCM is responsible for coordinating a formal transition team meeting.

Three months prior to the youth "aging out" of the PCSC waiver, the family's wraparound facilitator/TCM schedules a CFT/TCM meeting to develop a formal transition plan with action steps and transitional services. The child/youth person-centered plan must be signed by the wraparound facilitator/TCM as well as the family/youth. The family/youth signature designates that they approve of the transition plan. After the meeting, appropriate referrals are made by the wraparound facilitator/TCM to ensure appropriate supports and services are put in place upon the child/youth aging out of the waiver. The child/youth's transition plan specifies transitional services being pursued on their behalf and contains evidence that appropriate referrals/coordination have been initiated.

Appendix B-2: Individual Cost Limit

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one).* Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

☐	**No Cost Limit**. The State does not apply an individual cost limit. *Do not complete Item B-2-b or Item B-2-c*.
☐	**Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c*. The limit specified by the State is *(select one)*:
☐	**%** — A level higher than 100% of the institutional average Specify the percentage:
☐	Other *(specify)*:
☐	**Institutional Cost Limit**. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c*.
☐	**Cost Limit Lower Than Institutional Costs**. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c*.
	The cost limit specified by the State is *(select one)*:
☐	**The following dollar amount**: Specify dollar amount:
	The dollar amount *(select one)*:
☐	**Is adjusted each year that the waiver is in effect by applying the following formula:** Specify the formula:
☐	**May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
☐	**The following percentage that is less than 100% of the institutional average:**

	☐	**Other:** *Specify:*

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

☐	**The participant is referred to another waiver that can accommodate the individual's needs.**
☐	**Additional services in excess of the individual cost limit may be authorized.** Specify the procedures for authorizing additional services, including the amount that may be authorized:
☐	**Other safeguard(s)** *(Specify)*:

Appendix B-3: Number of Individuals Served

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	240
Year 2	290
Year 3	360
Year 4 (only appears if applicable based on Item 1-C)	420
Year 5 (only appears if applicable based on Item 1-C)	480

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

f participants that it serves at any point in time

pants that it serves at any point in time during a

The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	200
Year 2	250
Year 3	300
Year 4 (only appears if applicable based on Item 1-C)	350
Year 5 (only appears if applicable based on Item 1-C)	400

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

☐ **Not applicable**. **The state does not reserve capacity.**

☐ **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Table B-3-c

Waiver Year	**Purpose** (provide a title or short description to use for lookup):	**Purpose** (provide a title or short description to use for lookup):	**Purpose** (provide a title or short description to use for lookup):
	Institutional Diversion or Step-down		
	Purpose (describe):	**Purpose** (describe):	**Purpose** (describe):
	Leaving institutions or being diverted from institutions.		
	Describe how the amount of reserved capacity was determined:	**Describe how the amount of reserved capacity was determined:**	**Describe how the amount of reserved capacity was determined:**
	The number of children leaving institutions and needing support to remain in community.		
	Capacity Reserved	**Capacity Reserved**	**Capacity Reserved**
Year 1	5		
Year 2	5		
Year 3	5		
Year 4 (only if applicable based on Item 1-C)	5		
Year 5 (only if applicable based on Item 1-C)	5		

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one):*

☐	**The waiver is not subject to a phase-in or a phase-out schedule.**
☒	**The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an *intra-year* limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

☐	**Waiver capacity is allocated/managed on a statewide basis.**
☒	**Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:**

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Entry to the waiver is offered to individuals based on the date of their application for the waiver (first come first served basis). SCDHHS maintains the waiver access to ensure equitable distribution of waiver openings in all geographic areas covered by the waiver and to ensure that no one region maintains its own waiting list.

B-3: Number of Individuals Served - Attachment #1

Waiver Phase-In/Phase Out Schedule

Based on Waiver Proposed Effective Date:

a. The waiver is being *(select one)*:

☐	Phased-in
☐	Phased-out

b. **Phase-In/Phase-Out Time Schedule.** Complete the following table:

Beginning (base) number of Participants:

Phase-In or Phase-Out Schedule			
	Waiver Year:		
Month	**Base Number of Participants**	**Change in Number of Participants**	**Participant Limit**

c. **Waiver Years Subject to Phase-In/Phase-Out Schedule** *(check each that applies)*:

Year One	Year Two	Year Three	Year Four	Your Five
☐	☐	☐	☐	☐

d. **Phase-In/Phase-Out Time Period**. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. 1. State Classification. The State is a *(select one)*:

☐	§1634 State
☐	SSI Criteria State
☐	209(b) State

2. Miller Trust State.

Indicate whether the State is a Miller Trust State ***(select one).***

☐	No
☐	Yes

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)			
☐	Low income families with children as provided in §1931 of the Act		
☐	SSI recipients		
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121		
☐	Optional State supplement recipients		
☐	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*		
	☐	100% of the Federal poverty level (FPL)	
	☐ %	of FPL, which is lower than 100% of FPL Specify percentage:	
☐	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)		
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)		
☐	Medically needy in 209(b) States (42 CFR §435.330)		
☐	Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)		
☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:		
	All other mandatory and optional groups under the State Plan.		

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- ☐ **No**. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
- ☐ **Yes**. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5*.
  - ☐ All individuals in the special home and community-based waiver group under 42 CFR §435.217
  - ☐ Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:
    - ☐ A special income level equal to (select one):
      - ☐ 300% of the SSI Federal Benefit Rate (FBR)
      - ☐ ____ % A percentage of FBR, which is lower than 300% (42 CFR §435.236)

        Specify percentage:
      - ☐ $ ____ A dollar amount which is lower than 300%

        Specify percentage:
    - ☐ Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
    - ☐ Medically needy without spend down in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
    - ☐ Medically needy without spend down in 209(b) States (42 CFR §435.330)
    - ☐ Aged and disabled individuals who have income at: *(select one)*
      - ☐ 100% of FPL
      - ☐ ____ % of FPL, which is lower than 100%
    - ☐ Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:

Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217.

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

○	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act. *Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

☐	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (*select one*):	
	☐	Use *spousal* post-eligibility rules under §1924 of the Act. *Complete Items B-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.*
	☐	Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*
☐	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. *Complete Item B-5-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*	

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules. However, for the five-year period beginning on January 1, 2014, post-eligibility treatment-of-income rules may not be determined in accordance with B-5-b-1 and B-5-c-1, because use of spousal eligibility and post-eligibility rules are mandatory during this time period.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b-1. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ☐ The following standard included under the State plan
  (Select one):
  - ☐ **SSI standard**
  - ☐ **Optional State supplement standard**
  - ☐ **Medically needy income standard**
  - ☐ **The special income level for institutionalized persons**
    (select one):
    - ☐ **300% of the SSI Federal Benefit Rate (FBR)**
    - ☐ ____ % **A percentage of the FBR, which is less than 300%**
      Specify the percentage:
    - ☐ $ ____ **A dollar amount which is less than 300%.**
      Specify dollar amount:
  - ☐ ____ % A percentage of the Federal poverty level
    Specify percentage:
  - ☐ **Other standard included under the State Plan**
    Specify:
- ☐ **The following dollar amount** Specify dollar amount: $ ____ If this amount changes, this item will be revised.
- ☐ **The following formula is used to determine the needs allowance:**
  Specify:
- ☐ Other
  Specify:

ii. Allowance for the spouse only (*select one*):

- ☐ **Not Applicable**

Specify the amount of the allowance (*select one*):

- ☐ **SSI standard**
- ☐ **Optional State supplement standard**
- ☐ **Medically needy income standard**
- ☐ **The following dollar amount:** Specify dollar amount: $ ____ If this amount changes, this item will be revised.

☐	**The amount is determined using the following formula:** *Specify:*

iii. Allowance for the family *(select one)*:

☐	**Not Applicable *(see instructions)***
☐	**AFDC need standard**
☐	**Medically needy income standard**
☐	**The following dollar amount:** $ Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
☐	**The amount is determined using the following formula:** *Specify:*
☐	**Other** *Specify:*

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

☐	**Not applicable *(see instructions)*** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
☐	**The State does not establish reasonable limits.**
☐	**The State establishes the following reasonable limits** *Specify*:
	1. Eyeglasses not otherwise covered by the Medicaid program, not to exceed a total of $108 per occurrence for lenses, frames and dispensing fee. A licensed optometrist or ophthalmologist must certify the necessity for eyeglasses. 2. Dentures. A one-time expense not to exceed $651.00 per plate or $1320.00 for one full pair of dentures. A licensed dental practitioner must certify necessity. An expense for more than one pair of dentures must be prior approved by State DHHS. 3. Denture Repair. Justified as necessary by a licensed dental practitioner. Not to exceed

	$77.00 per occurrence. 4. Hearing Aids. A one-time expense. Not to exceed $1000.00 for one or $2000.00 for both. Necessity must be certified by a licensed practitioner. An expense for more than one hearing aid must be prior approved by State DHHS. 5. Physician and other medical practitioner visits that exceed the yearly limit, not to exceed $20 per visit. 6. Other non-covered medical expenses that are recognized by State law but not covered by Medicaid, not to exceed $20 per item/service. These non-covered medical expenses must be prescribed by a licensed practitioner and prior approved by State DHHS. 7. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c-1. Regular Post-Eligibility Treatment of Income: 209(B) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):

- ⊣H The following standard included under the State plan *(select one)*
  - ⊣H The following standard under 42 CFR §435.121
    Specify:
    [ ]
  - ⊣H Optional State supplement standard
  - ⊣H Medically needy income standard
  - ⊣H The special income level for institutionalized persons *(select one):*
    - ⊣H 300% of the SSI Federal Benefit Rate (FBR)
    - ⊣H % A percentage of the FBR, which is less than 300%
      Specify percentage:
    - ⊣H $ A dollar amount which is less than 300% of the FBR
      Specify dollar amount:
  - ⊣H % A percentage of the Federal poverty level
    Specify percentage:
  - ⊣H Other standard included under the State Plan (specify):
    [ ]
- ⊣H The following dollar amount: $ [ ] Specify dollar amount: If this amount changes, this item will be revised.
- ⊣H The following formula is used to determine the needs allowance
  Specify:
  [ ]
- ⊣H Other (specify)
  [ ]

ii. <u>Allowance for the spouse only</u> (*select one*):

- ⊣H Not Applicable (see instructions)
- ⊣H The following standard under 42 CFR §435.121
  Specify:
  [ ]
- ⊣H Optional State supplement standard

☐	Medically needy income standard		
☐	The following dollar amount: Specify dollar amount:	$	If this amount changes, this item will be revised.
☐	The amount is determined using the following formula: *Specify:*		

iii. <u>Allowance for the family</u> *(select one)*

☐	Not applicable *(see instructions)*		
☐	AFDC need standard		
☐	Medically needy income standard		
☐	The following dollar amount: Specify dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
☐	The amount is determined using the following formula: *Specify:*		
☐	Other (specify):		

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

☐	Not applicable *(see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.*
☐	The State does not establish reasonable limits.
☐	The State establishes the following reasonable limits *(specify)*:

NOTE: Items B-5-b-2 and B-5-c-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

State:	
Effective Date	

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b-2. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ☐ The following standard included under the State plan
  (Select one):
  - ☐ **SSI standard**
  - ☐ **Optional State supplement standard**
  - ☐ **Medically needy income standard**
  - ☐ **The special income level for institutionalized persons**
    (select one):
    - ☐ **300% of the SSI Federal Benefit Rate (FBR)**
    - ☐ ____ % **A percentage of the FBR, which is less than 300%**
      Specify the percentage:
    - ☐ $ ____ **A dollar amount which is less than 300%.**
      Specify dollar amount:
  - ☐ ____ % **A percentage of the Federal poverty level**
    Specify percentage:
  - ☐ **Other standard included under the State Plan**
    Specify:
- ☐ **The following dollar amount** $ ____ If this amount changes, this item will be revised.
  Specify dollar amount:
- ☐ **The following formula is used to determine the needs allowance:**
  Specify:
- ☐ **Other**
  Specify:

ii. Allowance for the spouse only (*select one*):

- ☐ **Not Applicable**
- ☐ **The State provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**
  Specify:

Specify the amount of the allowance (*select one*):

☐	**SSI standard**		
☐	**Optional State supplement standard**		
☐	**Medically needy income standard**		
☐	**The following dollar amount:** Specify dollar amount:	$	If this amount changes, this item will be revised.
☐	**The amount is determined using the following formula:** *Specify:*		

iii. Allowance for the family *(select one)*:

☐	**Not Applicable *(see instructions)***		
☐	**AFDC need standard**		
☐	**Medically needy income standard**		
☐	**The following dollar amount:** Specify dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
☐	**The amount is determined using the following formula:** *Specify:*		
☐	**Other** *Specify:*		

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

☐	**Not applicable *(see instructions)*** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
☐	**The State does not establish reasonable limits.**
☐	**The State establishes the following reasonable limits** *Specify*:
	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c-2. Regular Post-Eligibility Treatment of Income: 209(B) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ☐ The following standard included under the State plan
  (Select one):
  - ☐ **The following standard under 42 CFR §435.121:**
    Specify:
  - ☐ **Optional State supplement standard**
  - ☐ **Medically needy income standard**
  - ☐ **The special income level for institutionalized persons**
    (select one):
    - ☐ **300% of the SSI Federal Benefit Rate (FBR)**
    - ☐ % **A percentage of the FBR, which is less than 300%**
      Specify the percentage:
    - ☐ $ **A dollar amount which is less than 300%.**
      Specify dollar amount:
  - ☐ % **A percentage of the Federal poverty level**
    Specify percentage:
  - ☐ **Other standard included under the State Plan**
    Specify:
- ☐ **The following dollar amount** Specify dollar amount: $ If this amount changes, this item will be revised.
- ☐ **The following formula is used to determine the needs allowance:**
  Specify:
- ☐ **Other**
  Specify:

ii. Allowance for the spouse only (*select one*):

- ☐ **Not Applicable**
- ☐ **The State provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

	Specify:

Specify the amount of the allowance (*select one*):

☐	**The following standard under 42 CFR §435.121:** *Specify:*		
☐	**Optional State supplement standard**		
☐	**Medically needy income standard**		
☐	**The following dollar amount:** Specify dollar amount:	$	If this amount changes, this item will be revised.
☐	**The amount is determined using the following formula:** *Specify:*		

iii. <u>Allowance for the family</u> *(select one)*:

☐	**Not Applicable *(see instructions)***		
☐	**AFDC need standard**		
☐	**Medically needy income standard**		
☐	**The following dollar amount:** Specify dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
☐	**The amount is determined using the following formula:** *Specify:*		
☐	**Other** *Specify:*		

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

☐	**Not applicable *(see instructions)*** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

☐	**The State does not establish reasonable limits.**
☐	**The State establishes the following reasonable limits** *Specify*:

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

*(select one)***:**

☐	**SSI Standard**		
☐	**Optional State supplement standard**		
☐	**Medically needy income standard**		
☐	**The special income level for institutionalized persons**		
☐	%	Specify percentage:	
☐	**The following dollar amount:**	$	If this amount changes, this item will be revised
☐	**The following formula is used to determine the needs allowance:** *Specify formula:*		
☐	**Other** *Specify***:**		

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

☐	**Allowance is the same**
☐	**Allowance is different.** *Explanation of difference:*

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

☐	**Not applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

ㄴㅐ	**The State does not establish reasonable limits.**
ㄱ	**The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

NOTE: Items B-5-e, B-5-f and B-5-g only apply for the five-year period beginning January 1, 2014. If the waiver is effective during the five-year period beginning January 1, 2014, and if the state indicated in B-5-a that it uses spousal post-eligibility rules under §1924 of the Act before January 1, 2014 or after December 31, 2018, then Items B-5-e, B-5-f and/or B-5-g are not necessary. The state's entries in B-5-b-2, B-5-c-2, and B-5-d, respectively, will apply.

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State and §1634 state – 2014 through 2018. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ☐ The following standard included under the State plan
  (Select one):
  - ☐ **SSI standard**
  - ☐ **Optional State supplement standard**
  - ☐ **Medically needy income standard**
  - ☐ **The special income level for institutionalized persons**
    (select one):
    - ☐ **300% of the SSI Federal Benefit Rate (FBR)**
    - ☐ % **A percentage of the FBR, which is less than 300%**
      Specify the percentage:
    - ☐ $ **A dollar amount which is less than 300%.**
      Specify dollar amount:
  - ☐ % **A percentage of the Federal poverty level**
    Specify percentage:
  - ☐ **Other standard included under the State Plan**
    Specify:
- ☐ **The following dollar amount** Specify dollar amount: $ If this amount changes, this item will be revised.
- ☐ **The following formula is used to determine the needs allowance:**
  Specify:
- ☐ **Other**
  Specify:

ii. Allowance for the spouse only (*select one*):

- ☐ **Not Applicable**
- ☐ **The State provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**
  Specify:

Specify the amount of the allowance (*select one*):

- ☐ **SSI standard**

☐	**Optional State supplement standard**		
☐	**Medically needy income standard**		
☐	**The following dollar amount:** Specify dollar amount:	$	If this amount changes, this item will be revised.
☐	**The amount is determined using the following formula:** *Specify:*		

iii. Allowance for the family *(select one)*:

☐	**Not Applicable *(see instructions)***		
☐	**AFDC need standard**		
☐	**Medically needy income standard**		
☐	**The following dollar amount:** Specify dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
☐	**The amount is determined using the following formula:** *Specify:*		
☐	**Other** *Specify:*		

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

☐	**Not applicable *(see instructions)*** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
☐	**The State does not establish reasonable limits.**
☐	**The State establishes the following reasonable limits** *Specify*:
	The State uses the same reasonable limits as are used for regular (non-spousal) post eligibility.

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility: 209(b) State – 2014 through 2018. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- The following standard included under the State plan
  (Select one):
  - **The following standard under 42 CFR §435.121:**
    Specify:
  - **Optional State supplement standard**
  - **Medically needy income standard**
  - **The special income level for institutionalized persons**
    (select one):
    - **300% of the SSI Federal Benefit Rate (FBR)**
    - % — **A percentage of the FBR, which is less than 300%**
      Specify the percentage:
    - $ — **A dollar amount which is less than 300%.**
      Specify dollar amount:
  - % — **A percentage of the Federal poverty level**
    Specify percentage:
  - **Other standard included under the State Plan**
    Specify:
- **The following dollar amount** — Specify dollar amount: $ — If this amount changes, this item will be revised.
- **The following formula is used to determine the needs allowance:**
  Specify:
- **Other**
  Specify:

ii. Allowance for the spouse only (*select one*):

- **Not Applicable**
- **The State provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**
  Specify:

Specify the amount of the allowance (*select one*):

☐	**The following standard under 42 CFR §435.121:** *Specify:*
☐	**Optional State supplement standard**
☐	**Medically needy income standard**
☐	**The following dollar amount:** $ If this amount changes, this item will be revised. Specify dollar amount:
☐	**The amount is determined using the following formula:** *Specify:*

iii. Allowance for the family *(select one)*:

☐	**Not Applicable *(see instructions)***
☐	**AFDC need standard**
☐	**Medically needy income standard**
☐	**The following dollar amount:** $ Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
☐	**The amount is determined using the following formula:** *Specify:*
☐	**Other** *Specify:*

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

☐	**Not applicable *(see instructions)*** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
☐	**The State does not establish reasonable limits.**

☐	**The State establishes the following reasonable limits** *Specify*:

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – 2014 through 2018

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

*(select one)***:**

☐	**SSI Standard**		
☐	**Optional State supplement standard**		
☐	**Medically needy income standard**		
☐	**The special income level for institutionalized persons**		
☐	%	Specify percentage:	
☐	**The following dollar amount:**	$	If this amount changes, this item will be revised
☐	**The following formula is used to determine the needs allowance:** *Specify formula:*		
☐	**Other** *Specify***:**		

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

☐	**Allowance is the same**
☐	**Allowance is different.** *Explanation of difference:*

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*	
☐	**Not applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
☐	**The State does not establish reasonable limits.**
☐	**The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B-6: Evaluation / Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for waiver services:

i.	**Minimum number of services**. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is*:* 1
ii.	**Frequency of services**. The State requires (select one):
☐	**The provision of waiver services at least monthly**
☑	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

☑	**Directly by the Medicaid agency**
☑	**By the operating agency specified in Appendix A**
☑	**By an entity under contract with the Medicaid agency.** *Specify the entity*:
☐	**Other** *Specify*:
	Credentialed individuals meeting the requirements of a Licensed Practitioner of the Healing Arts (LPHA) or a Wraparound facilitator/TCM who is certified by SCDHHS as meeting high-fidelity wraparound standards. LPHAs and Wraparound facilitator/TCMs may not provide other services to the child (i.e., meeting conflict of interest standards under the HCBS regulation). LPHA includes a psychiatrist, psychologist, LMSW, LPC, LISW-CP, LISW-AP, or LMFT.

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The Child and Adolescent Service Intensity Instrument (CASII) is performed by credentialed individuals meeting the requirements of a Licensed Practitioner of the Healing Arts (LPHA) or a Wraparound

Facilitator/TCM who is experienced in human services or social services, a bachelor's degree in a human service or social sciences related field and one year of experience with children with serious emotional or behavioral health challenges employed by a public entity. The CASII is forwarded to SCDHHS for review.

To be certified, the individual must do the following:

- Completion of the required training for evidence-based, high-fidelity wraparound process for wraparound facilitator/TCMs and supervision by supervisors with State certification by a nationally recognized high fidelity wraparound trainer.
- Pass a South Carolina criminal history background check, child abuse and neglect screen, motor vehicle screens, and excluded provider screen.
- Demonstration of use of evidence-based wraparound standards as approved by SCDHHS through ongoing participation in wraparound fidelity monitoring.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Level of Care is determined using the Child and Adolescent Service Intensity Instrument (CASII).

The CASII is completed initially when the child is referred for services and annually thereafter.

The CASII is completed based on a face-to-face interview with the child (and parent(s) when possible) and additional supporting information. The CASII takes into consideration child development and the importance of the parents and the community in supporting the child. It is used to determine the intensity of needed services. The CASII has six dimensions: Risk of Harm, Functional Status, Co-Morbidity, Recovery Environment, Resiliency and Treatment History, and Acceptance and Engagement. Each dimension has a five-point rating scale. For each of the five possible ratings within each dimension, a set of criteria is clearly defined. Only one criterion needs to be met for that rating to be selected.

Re-evaluation: In addition to input from the child/youth and family, the wraparound facilitator/TCM/LPHA will consider information gathered from the CASII Assessment. Every 12 months, or more frequently if determined necessary by the wraparound facilitator/TCM/LPHA, or CFT/TCM due to a significant change in the child/youth's condition or needs, a child/youth's medical need level of care shall be reevaluated for continued participation in the program. A child/youth is considered to meet the hospital facility level of care if the child/youth would be in need of a hospital placement but for the continued receipt of waiver services. The reevaluation also takes into account clinical evidence of therapeutic clinical goals that must be met before the individual can transition to a less intensive level of care and clinical evidence of symptom improvement.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

☒	**The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**

¬	**A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.** Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.
	The State has compared the CASII assessment tool to the hospital certification requirements and found that all hospital certification requested information and values are included in the CASII. The CASII has demonstrated strong reliability across users and validity relative to other assessments as well as in predicting treatment and level of care needs. The CASII recommendation for level of care determination will automatically be calculated based on the behavioral health algorithm for children set at the same levels as the South Carolina hospital levels of care when the comprehensive CASII or reassessment is completed. This results in comparability across eligibility determinations that are fully comparable to the SCDHHS hospital certification level of care criteria.

f. Process for Level of Care Evaluation/Reevaluation. Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

There are two areas of eligibility a child must meet: Clinical (also called Functional) and Financial (also called Medicaid).

Clinical Evaluation. A wraparound facilitator/TCM/LPHA must determine that the child meets the targeting criteria of the waiver and the functional criteria outlined above. Key features of clinical eligibility include:

- Age - A child must be between 0 and through the age of 21 years old.
- Diagnosis - a mental health diagnosis meeting the targeting criteria in Section B-1 above must be present.
- Functional Assessment - All children on the waiver must meet minimum scores for the hospital level of care as determined by the CASII level of care Decision Model.

Case Management Choice and Release of Information Form - Documentation that the parents or caregivers of the child/youth chose the waiver rather than hospitalization or nursing facility placement

Financial Eligibility - If a child/youth is not already eligible for Medicaid, a financial eligibility determination for Medicaid is completed following the level of care determination. A financial redetermination occurs annually.

Annual Revaluation - The need for HCBS waiver services is re-evaluated at a minimum annually, but also any time the family feels it is appropriate, as needs change, and/or as goals are completed. The format for re-evaluating the level of care is guided by the clinical evaluations of the licensed professional, the progress towards goals and objectives, and the CASII which is completed annually. The re-evaluation process does differ from the Initial Evaluation. In the initial evaluation, the credentialed individual meeting the requirements of a LPHA or Wraparound facilitator/TCM conducts standard assessments (CASII), a clinical narrative and clinical indication that the youth is determined to be in need of State psychiatric hospitalization placement in absence of HCBS waiver services. The re-evaluation focuses on whether the child/youth continues to be determined to be in need of psychiatric hospitalization level of care and a clinical narrative. This information is captured on the Annual Review Form.

Notice of Action - When a child/youth is found clinically eligible or ineligible during the initial evaluation or the semi-annual re-evaluation, their family receives a Notice of Action advising them of the status of clinical eligibility.

All clinical eligibility documentation including the initial evaluation, the semi-annual re-evaluation and the notice of action are to be maintained in the child's/youth's clinical record at the agency employing the wraparound facilitator/TCM.

All decisions by Wraparound facilitator/TCM/LPHA are reviewed by State staff for consistency with State Guidelines.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

☐	**Every three months**
☐	**Every six months**
☐	**Every twelve months**
☐	**Other schedule** *Specify* the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

☐	**The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
☐	**The qualifications are different.** *Specify the qualifications:*

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify)*:

SCDHHS and the waiver child's/youth's wraparound facilitator/TCM both monitor the annual re-evaluation date through a tickler system to ensure that the level of care is completed every twelve months or if there is a significant change in the child/youth's condition or needs. SCDHHS provides guidance and oversight to the wraparound facilitator/TCMs to ensure that the level of care determinations are completed as required.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The original documents are housed with the CFT/TCM with copies retained by SCDHHS.

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: **Level of Care Assurance/Sub-assurances**

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-assurances:

a. Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	*Number and percent of individuals referred who had a brief screen indicating the child/youth could meet LOC prior to being placed on a waiting list or being referred for a full evaluation.* *Numerator: Number of referees who had brief screen indicating the child/youth met LOC prior to a full evaluation* *Denominator(n): Total number of referrals*
Data Source *(Select one) (Several options are listed in the on-line application):* ***Record reviews, on-site***	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*

	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval =*
	⌙ *Other Specify:*	⌐ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*	
			⌙ *Other Specify:*

Performance Measure:	*Number and percent of new enrollees who had an evaluation indicating the child/youth met LOC prior to receipt of services.* *Numerator: Number of new enrollees who had an evaluation indicating the child/youth met LOC prior to receipt of services* *Denominator(n): Total number new enrollees*
Data Source *(Select one) (Several options are listed in the on-line application):* ***Record reviews, off-site***	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⌐ *State Medicaid Agency*	⌙ *Weekly*	⌐ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval =*
	⌙ *Other Specify:*	⌐ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*	
			⌙ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⁼ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other Specify:*	⁼ *Annually*
	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

b Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	*Number and percent of Level of Care assessments completed within 365 days.* *Numerator: Number of Level of Care assessments completed before 365 days after the last LOC assessment* *Denominator: Number of enrollees*
Data Source *(Select one) (Several options are listed in the on-line application):* ***Record reviews, off-site***	
If 'Other' is selected, specify:	

	Responsible Party for	***Frequency of data***	***Sampling Approach***

	data collection/generation *(check each that applies)*	***collection/generation:*** *(check each that applies)*	*(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⊏ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval =*
	⌙ *Other Specify:*	⊏ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*	
			⌙ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⊏ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other Specify:*	⊏ *Annually*
	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

c Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine the initial participant level of care.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	*Number and percent of children/youths with initial LOC determinations reviewed that were completed using the process required by the approved waiver.* *Numerator: Number of children/youths with initial LOC determinations reviewed that were completed using the process required by the approved waiver* *Denominator(n): Total number of new enrollees*
Data Source *(Select one) (Several options are listed in the on-line application):* ***Record reviews, off-site***	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⊏ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval =*
	⌙ *Other Specify:*	⊏ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*	
			⌙ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⊏ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other Specify:*	⊏ *Annually*
	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

ii *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

b. Methods for Remediation/Fixing Individual Problems

i *Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.*

When issues/problems/concerns are discovered by SCDHHS through formal quality review processes the responsible party is notified by SCDHHS staff. SCDHHS staff identifies the problem, makes the responsible party aware of the problem and ensures that they have appropriate information to correct the problem. SCDHHS staff formally issue a statement of deficiency requiring a corrective action plan (CAP). If SCDHHS deems the problem/issue/concern to cause imminent danger to the waiver operations or children/youths, SCDHHS notifies the responsible party and they are restricted from conducting waiver related supports and services until the issue is resolved and SCDHHS accepts the CAP. The CAP response must be submitted within 30 days of the receipt of the CAP by the responsibility party. The corrective action plan both addresses immediate problems and identifies how the problems can be avoided in the future. Documentation is submitted to SCDHHS to support corrective actions as proof that the issue has been addressed. SCDHHS reviews corrective action plans to ensure that they address the underlying issues/concerns. SCDHHS reviews past quality review findings at future reviews to ensure that the issues have not continued. Failure to submit and implement

a corrective action plan may result in the provider being excluded from the waiver.

ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*
	☐ *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	☐ *Annually*
		☐ *Continuously and Ongoing*
		☐ *Other: Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

☐	**No**
☐	**Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

As part of the screening process, a member of the CFT/TCM, which may be the wraparound facilitator/TCM or the peer navigator, meets with the family to discuss all aspects of the waiver. The CFT/TCM member answers questions and addresses any concerns. During this conversation, the CFT/TCM member discusses Freedom of Choice. Regardless of which option the family chooses – institutional or home and community-based services – they are required to sign a Freedom of Choice Form, indicating their selection. The family is assured that they will not be penalized in any way or denied services due to their choice.

b. Maintenance of Forms. Per 45 CFR § 92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The original documents are housed with the CFT/TCM files.

Appendix B-8: Access to Services by Limited English Proficient Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The waiver intake process ensures that children/youths' language needs are assessed. Where appropriate, interpreter services are provided. In addition, prior to enrollment approval, all providers of waiver services must have a protocol system in place that allows access to services by persons with limited English proficiency. Designated staff within the provider agencies are responsible for assuring compliance and access to services by persons with limited English proficiency.

SCDHHS is responsible for monitoring the compliance process. The provider agency can request assistance from SCDHHS. SCDHHS assists the provider agency with identifying resources when/if necessary. DHHS requires each provider agency to be in compliance with Title VI. The State establishes a grievance procedure as outlined in Appendix F to assure that everyone is given a fair and timely review of all complaints alleging discrimination. Prior to enrollment approval, all providers must agree, in writing, to the "Assurance of Compliance" statement.

The DHHS waiver staff is responsible for maintaining records documenting the complaints filed and actions that are taken to bring resolution to the complaint(s). These records are reviewed by SCDHHS, as part of the overall quality assurance process. The DHHS waiver staff is responsible for notifying SCDHHS quality assurance process of any discrimination complaints that have been filed.

Appendix C: Participant Services

Appendix C-1/C-3: Summary of Services Covered and Services Specifications

C-1-a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	°	High Fidelity Wraparound
Homemaker	⌐	
Home Health Aide	⌐	
Personal Care	⌐	
Adult Day Health	⌐	
Habilitation	°	Employment Skills Development Community Psychiatric Support and Treatment (CPST)
Residential Habilitation	⌐	
Day Habilitation	⌐	
Prevocational Services	°	Career Exploration and Assessment
Supported Employment	°	Intensive Supported Employment
Education	⌐	
Respite	°	
Day Treatment	⌐	
Partial Hospitalization	⌐	
Psychosocial Rehabilitation	⌐	
Clinic Services	⌐	
Live-in Caregiver (42 CFR §441.303(f)(8))	⌐	

Other Services *(select one)*	
⌐	Not applicable
⌐	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	Individualized Directed Goods and Services

b.	Non-Medical Transportation
c.	
d.	
e.	
f.	
g.	
h.	
i.	

Extended State Plan Services *(select one)*

☐	Not applicable
☒	The following extended State plan services are provided *(list each extended State plan service by service title)*:
a.	
b.	
c.	

Supports for Participant Direction *(check each that applies))*

☐	The waiver provides for participant direction of services as specified in Appendix E. The waiver includes Information and Assistance in Support of Participant Direction, Financial Management Services or other supports for participant direction as waiver services.
○	The waiver provides for participant direction of services as specified in Appendix E. Some or all of the supports for participant direction are provided as administrative activities and are described in Appendix E.
☒	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	☐	
Financial Management Services	☐	

Other Supports for Participant Direction *(list each support by service title)*:

a.	
b.	
c.	

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
HCBS Taxonomy **– Service Title: High Fidelity Wraparound**	
Category 1:	Sub-Category 1:
01-Case Management	01010 – Case management
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Service Definition (Scope)**:**	
The function of performing wraparound facilitation is to form the child and family team consisting of the child/youth's family, extended family, and other community members involved with the child/youth's daily life for the purpose of producing a community-based, person-centered plan. This includes working with the family to identify who should be involved in the child and family team and assembly of the child and family team for the person-centered plan development meeting. The wraparound facilitator guides the person-centered plan development process of the team to assure that waiver rules are followed. The wraparound facilitator also is responsible for reassembling the team when subsequent person-centered plan review and revision are needed, at minimum on a quarterly basis to review the person-centered plan and more frequently when changes in the child/youth's circumstances warrant changes in the person-centered plan. The wraparound facilitator emphasizes building collaboration and ongoing coordination among the family, caretakers, service providers, and other formal and informal community resources identified by the family. The wraparound process promotes flexibility to ensure that appropriate and effective service delivery to the child/youth and family/caregivers. Facilitators are certified after completion of specialized training in the wraparound philosophy, waiver rules and processes, waiver eligibility and associated paperwork, structure of the child and family team, and meeting facilitation. The role of the peer navigator within the CFT is to disseminate and provide information to the youth and family about self-direction and navigating the intake and enrollment process, assist families with the understanding their rights processes, assist with the freedom of choice form, assist with monitoring on an on-going basis and provide assistance with training especially assisting the family during the development of a person-centered plan to ensure that the child and family's needs and preferences are clearly understood even though a case manager is responsible for the development of the person-centered plan. The wraparound facilitator – not the peer navigator - is responsible for the development of the person-centered plan. The Licensed Practitioner of the Healing Art's role is to assess the needs of the child/youth using the CASII and CAFAS. Together, the child and family team perform the four functions of HCBS care management: assessment, person-centered planning, referral to services, and monitoring of health and welfare and service delivery. Services provided to children and youth must include communication and coordination with the family and/or legal guardian. Wraparound Facilitation includes coordination with other child serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the child/youth's medical record. Child and family teams must receive ongoing and regular clinical supervision by a person meeting the qualifications of a Licensed Practitioner of the Healing Arts with experience regarding this specialized mental health service, and such shall be available at all times to provide back up, support, and/or consultation.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Wraparound facilitation may not be provided at the same time as targeted case management to address the unique needs of waiver children/youths living in the community and does not duplicate any Medicaid State Plan Service or services otherwise available to the recipient at no cost. Note: children under the waiver who decline wraparound facilitation services may instead receive TCM for their HCBS assessment, person-centered planning, referral and monitoring. TCM may also be utilized for children under the waiver in intensive evidence-based practices such as Multi-systemic Therapy where the delivery of the evidence-based practice of wraparound facilitation would undermine the fidelity of the model.

Service Delivery Method *(check each that applies)*:	⌙	Child/youth-directed as specified in Appendix E	°	Provider managed

Specify whether the service may be provided by *(check each that applies):*	⌙	Legally Responsible Person	⌙	Relative	⌙	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	⌙	Individual. List types:	°	Agency. List the types of agencies:
				Care Management Entity

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Care Management Entity (CME)		The team must be credentialed by a national accrediting body as meeting the standards of High Fidelity Wraparound and demonstrate continued use of evidence-based wraparound standards as approved by SCDHHS through ongoing participation in wraparound fidelity monitoring.	Comply with all SCDHHS standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications and enrollment. Each child and family team includes a wraparound facilitator and a credentialed individual meeting the requirements of a Licensed Practitioner of the Healing Arts or employed by a public entity (note the LPHA could be a psychiatrist, psychologist, LMSW, LPC, LISW-CP, LISW-AP, or LMFT). Note: the peer navigator is also on the child and family team but is administratively funded as the "supports broker" for self-direction. All members of the child and family team must receive High Fidelity Wraparound training and demonstrate on-going use of evidence-based wraparound standards through wraparound fidelity monitoring. The CAFAS is performed by professionals meeting the requirements of a credentialed individual meeting the requirements of a Licensed Practitioner of the Healing Arts or employed by a public entity and forwarded to SCDHHS for review.

			Wraparound Facilitator The wraparound facilitator must meet the following requirements: • A bachelor's degree in a human services or social sciences related field. • One year of experience with children with serious emotional or behavioral health challenges. • Completion of the required training for evidence-based, high fidelity wraparound process for wraparound facilitators. • Pass a South Carolina criminal history background check, child abuse and neglect screen, motor vehicle screens, and excluded provider screen. • Bilingual applicants and applicants with one year of experience with children with serious emotional or behavioral health challenges are encouraged to apply. **Wraparound Team Lead** The Wraparound Team Lead must meet the following minimum requirements: • Must have professional experience in human services or social services program. • A bachelor's degree in a human service or social sciences related field. • At least 3 years of experience with children with serious emotional and behavioral health challenges. • Experience in provision of high fidelity Wraparound and maintain agency standards as a regional mentor. • Completion of the required training for evidence-based, high fidelity wraparound process for wraparound facilitators. • Must also have experience in provision of high fidelity Wraparound and maintain agency standards as a regional

			mentor • Pass a South Carolina criminal history background check, child abuse and neglect screen, motor vehicle screens, and excluded provider screen. • Bilingual applicants are encouraged to apply. **Wraparound Coach/Supervisor** - Care Management Entities must also employ staff to lead the child and family teams. Requirements include the following: • Professional experience in human services or social services programs, a master's degree in a human services or social sciences related field • Must have two years of case management experience and experience with children with complex emotional or behavioral health challenges. • Requires a minimum of one year of supervisory experience. Must be licensed or have recently applied for licensure as a LMSW, LPC, LISW-CP, LISW-AP, or LMFT. • Completion of the required training and State credentialing process for wraparound facilitator supervisors. • If the coach or supervisor also functions, in part, as a wraparound facilitator, they must also meet the requirements for a wraparound facilitator described above. • The wraparound facilitator supervisor must provide regular supervision to wraparound facilitation service delivery staff, including completion of all supervisor requirements for wraparound fidelity monitoring. • The wraparound facilitator supervisor must have good interpersonal skills for supporting

			development in others. The supervisor should have a broad base of experience and possess a diverse view of what families need to live better lives. The supervisor must collaborate closely with other supervisors in other child-serving agencies in the community. A wraparound supervisor should demonstrate skills that support engaging people from different cultures, ages and backgrounds. A preferred supervisor characteristic is an understanding of, and experience with, different systems, including schools, behavioral health, child welfare, juvenile justice, health and others. The wraparound facilitator supervisor must oversee the work of the wraparound facilitation service delivery staff on an ongoing basis. **Licensed Practitioner of the Healing Arts or individual credentialed to provide the assessments employed by a public agency** Each CME must have a Licensed Practitioner of the Healing Arts providing clinical assessments. ▪ Must be licensed or have recently applied for licensure as a LMSW, LPC, LISW-CP, LISW-AP, or LMFT. Psychiatrist and psychologists are also eligible to fulfill this position or credentialed individual employed by a public entity • Completion of the required training for evidence-based, high fidelity wraparound process for wraparound facilitators. • Pass a South Carolina criminal history background check, child abuse and neglect screen, motor vehicle screens, and excluded provider screen. The Care Management Entity must ensure

			on-going training of all child and family team members either through contract with national bodies or by employing nationally certified trainers. The Care Management entity must ensure that all child and family team members meet all conflict of interest requirements in the HCBS regulation.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Care Management Entity	**SCDHHS**	**Annually**

Service Specification	
HCBS Taxonomy – **Service Title: Individual Goods and Services**	
Category 1:	Sub-Category 1:
17 – Other Services	17010 – Individually directed goods and services
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

Individual Goods and Services (IGS) are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the person-centered plan (including improving and maintaining the child/youth's opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; AND/OR promote inclusion in the community; AND/OR increase the child/youth's safety in the home environment; AND the child/youth does not have the funds to purchase the item or service or the item or service is not available through another source. Experimental or prohibited treatments are excluded. Individualized Goods and Services must be documented in the person-centered plan. Individual goods and services are available that:

- Are reflective of social and community supports that include free and low-cost resources, as well as cost-based services, that are fully integrated to the greatest extent possible into the community;
- Match local service options in a way that compliments traditional treatment services, explores varied approaches to wellness, and reflects the overall health, well-being, and community integration of the child/youth.

Allowable Categories:
Camp Funding may be requested for the cost of summer camp in a self-directed plan for a camp that is able to provide the needed safeguarding services and supports to achieve the person's valued outcomes. Camps can be either focused on supporting children/youths with disabilities or camps that are available to the general public. Not to exceed published fees.

Training/Coaching Classes available to the general public in any subject area that relates to a person's valued outcomes (Art, Dance, Exercise, Cooking, Computer Training, etc.) Sessions with a private trainer (physical education/exercise) may be covered as long as the service relates to a valued outcome). Classes must be related to a habilitative need in the child/youth's person-centered plan and not just for recreational purposes. Classes must be non-credit bearing; child/youth directed goods and services funding is for non-matriculating students. Not to exceed the published fees as outlined in the entity's published course fees.

Coaching/education for parent(s), spouse and advocates to attend/participate in educational opportunities (not covered by other public programs) that assist the child/youth and those close to them to achieve goals established in the child/youth's person-centered plan. This may include registration, and conference fees. Reimbursement for overnight lodging or travel not allowable.

Art or Play Therapy: Funding for art and or play therapy may be included in a person-centered plan when the service has been prescribed by the child/youth's medical doctor to ameliorate a specific medical

diagnosis/condition for which art or play therapy has recognized efficacy. Funding is not available to support vague goals such as “promote well-being,” “reduce stress,” or “promote relaxation.”

- Art, or Play Therapy: A consultant/contractor, who is a member of a profession that is under the jurisdiction of the SC Department of Labor, Licensing and Regulation and who meets certification requirements established by SCDHHS.
- There must be a corresponding valued outcome in the child/youth's plan. The hourly amount paid to the therapist cannot exceed the 90th percentile for the regional hourly wage for the therapeutic or consultant’s professional discipline (i.e., the standard occupational code) published by the Bureau of Labor Statistics (BLS) that can be queried at the following website: http://data.bls.gov/oes. The service must be outlined in the person-centered plan and justified by the child/youth’s medical doctor or licensed clinician and a corresponding valued outcome.
- Ordering, Treatment Plan & Documentation Requirements for therapy services: The request for funding must be accompanied by a written prescription from the child/youth’s medical doctor with a goal of treating a specific medical diagnosis/condition and shall support a specific valued outcome. The therapist conducts an initial assessment, reports findings, and proposes a treatment plan. The treatment plan outlines treatment goals, proposed therapeutic activities, and anticipated frequency and duration. The treatment plan acknowledges the child/youth's personal goals and supports a specific valued outcome(s) described in the person-centered plan. The treatment plan becomes active upon the referring/prescribing medical doctor’s review and written approval. On-going treatment services shall be delivered only in accordance with the approved treatment plan. Each session shall be documented with a brief treatment note outlining the therapeutic services/activities performed, duration, and response to treatment. The therapist provides periodic (at least semi-annual) progress reports to the referring/prescribing medical doctor. Such report reviews the child/youth’s progress toward goals and the efficacy of services to date and it proposes necessary updates/revisions to the treatment plan. The medical doctor reviews the child/youth’s progress and, if warranted, approves the updated treatment plan and continuation of services in writing.

Health Club/Organizational Memberships/Community Participation: Health club memberships, community membership dues, funding for a gym, health club or other community organization membership may be included in the person-centered plan for reasons of health and fitness or community integration in accordance with the child/youth’s valued outcomes. Membership is for child/youth only; no family memberships allowed with IGS funding. The club/organization must offer open enrollment to the public, and cannot be a private club with a closed membership where membership is available by invitation only. Payment not to exceed the entity’s published membership dues/fees specified.

Household-Related Items and Services: Item cannot be funded through any other funded program and may include appliances that assist a person to live more independently (i.e., a microwave oven for someone who cannot safely use a stove or oven). Appliance must benefit the child/youth and be related to a valued outcome as well as be related to health and safety.

Household support (cleaning, minor maintenance, snow removal, lawn mowing) only for children/youths not living in the family home.

Transition Programs for Individuals with Behavioral Health Diagnoses Tuition for non-credit bearing transition programs for children/youths with Behavioral Health Diagnoses who have already completed their educational program (i.e. ‘aged out’). The coursework must address a person’s valued outcomes and address skill building and employment outcomes. Programs may be provided in non-site based settings, on college campuses, but not in locations certified by DMH. Coursework may include training on personal care skills, and socialization skills, but this training is provided to support vocational outcomes for the person. To be funded via a person’s self-direction budget, the program cannot be funded by ACCESS-VR, IDEA or other funding sources. Services are time-limited and cannot exceed a two year timeframe. No room and board costs are

fundable. All staff, volunteers and trainers are screened for criminal background and excluded provider status. Published fees cannot be exceeded.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

$2,000 lifetime limit per child or youth.

Service Delivery Method *(check each that applies)*:	°	Participant-directed as specified in Appendix E	⌐	Provider managed

Specify whether the service may be provided by *(check each that applies):*	⌐	Legally Responsible Person	⌐	Relative	⌐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	°	Individual. List types:	°	Agency. List the types of agencies:
	Individuals hired or goods purchased by participants who self-direct		Private agency or private vendor	

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individuals hired or goods purchased by participants who self-direct			The state will verify that individuals meet the following qualifications: • Meets any applicable state regulations for the type of supply or service as described in the approved Individual Plan Prior to Employment • Be at least 18 years of age • Have high school or equivalent degree • Comply with all SCDHHS standards including regulations, policies and procedures related to provider qualifications • Complete SCDHHS required training, including training on the child/youth's person-centered plan and the child/youth's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs • Pass a South Carolina criminal history background check, child abuse and neglect screen, motor vehicle screens, and excluded provider screen • Have a valid driver's license from South Carolina or a contiguous state if the operation of a vehicle is necessary

			to provide the service .
Private agency or private vendor			The state will verify that the agency meets any applicable state regulations for the type of supply or service as described in the approved Individual Plan If the participant is purchasing direct supports, the agency will ensure that employees meet the following qualifications prior to employment: • Be at least 18 years of age • Have high school or equivalent degree • Comply with all SCDHHS standards including regulations, policies and procedures related to provider qualifications • Complete SCDHHS required training, including training on the child/youth's person-centered plan and the child/youth's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs • Pass a South Carolina criminal history background check, child abuse and neglect screen, motor vehicle screens, and excluded provider screen • Have a valid driver's license from South Carolina or a contiguous state if the operation of a vehicle is necessary to provide the service

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual	**SCDHHS or designee**	**Upon contracting and when used thereafter**
Agency	**SCDHHS or designee**	**Upon contracting and when used thereafter**

Service Specification	
HCBS Taxonomy **– Service Title: Career Exploration and Assessment**	
Category 1:	Sub-Category 1:
03 – Supported Employment	03030 – Career Planning
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

Career Exploration and Assessment is a person-centered, comprehensive employment planning and support service that provides assistance for program children/youths to obtain, maintain, or advance in competitive employment or self-employment. It is a focused, time limited service engaging a child/youth in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the State's minimum wage. The outcome of this service is documentation of the child/youth's stated career objective and a career plan, including any necessary education and training, used to guide child/youth employment support.

This service may include conducting community based career assessment. The assessment may include:

- conducting a review of the child/youth's work history, interests and skills;
- identifying types of jobs in the community that match the child/youth's interests, abilities, and skills;
- identifying situational assessments (including job shadowing or job tryouts) to assess the child/youth's interest and aptitude in a particular type of job; and/or
- developing a report that specifies recommendations regarding the child/youth's needs, preferences, abilities, and characteristics of an optimal work environment. The report must also specify if education, training, or skill development is necessary to achieve the child/youth's employment or career goals, with an indication of whether those elements may be addressed by other related services in the child/youth's person-centered plan or other sources.

Services must be delivered in a manner that supports the child/youth's communication needs including, but not limited to, age appropriate communication, translation services for children/youths that are of limited-English proficiency or who have other communication needs requiring translation.

The service also includes transportation as an integral component of the service, such as to a job shadowing opportunity, during the delivery of Career Exploration and Assessment.

Competitive and integrated employment, including self-employment, shall be considered the first option when serving persons with disabilities who are of working age. Documentation is maintained that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Categorically Needy (specify limits):
Career Exploration and Assessment may be authorized for up to 6 months in a benefit year, with multi-year service utilization and reauthorization only with explicit written Department approval. Total hours for this

service and Employment Skills Development may not exceed 40 hours per week. It may not be offered on the same day as Employment Skills Development.

Federal Financial Participation (FFP) is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- incentive payments made to an employer to encourage or subsidize the employer's participation in Job Finding services, and
- payments that are passed through to users of the Career Exploration services.

Service Delivery Method *(check each that applies)*:	⌐	Child/youth-directed as specified in Appendix E	°	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	⌐	Legally Responsible Person	⌐	Relative	⌐ Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	⌐	Individual. List types:	°	Agency. List the types of agencies:
				Career Exploration Agency

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Career Exploration Agency	State Business License or 501 (c) (3) status		Comply with all SCDHHS standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications and enrollment. Individuals working for or contracted with agencies must meet the following standards: • Be at least 18 years of age, and • Associates degree with 60 hours of equivalent experience, or • Bachelor's or Master's degree Ensure employees complete Department-required training, including training on the child/youth's person-centered plan and the child/youth's unique and/or disability-specific needs, which may include, but is not limited to, communication, mobility, and behavioral needs. Individuals employed by providers must: • Pass a South Carolina criminal history background check, child

			abuse and neglect screen, motor vehicle screens, and excluded provider screen. • Be state licensed (as applicable), or registered in their profession as required by State law. In the case of direct care personnel, possess certification through successful completion of training program as required by the Department.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Career Exploration Agency	SCDHHS or designee	Initially and annually thereafter

Service Specification	
HCBS Taxonomy – **Service Title: Employment Skills Development**	
Category 1:	Sub-Category 1:
04 – Day Services	04010 – Prevocational Services
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

Employment Skills Development services provide learning and work experiences, including volunteer work, where the child/youth can develop strengths and skills that contribute to employability in paid employment in integrated community settings. Services are aimed at furthering habilitation goals that lead to greater opportunities for competitive and integrated employment and career advancement at or above minimum wage. Employment Skills Development services are necessary, as specified in the person-centered plan, to support the child/youth to live and work successfully in home and community-based settings, enable the child/youth to integrate more fully into the community and ensure the health, welfare and safety of the child/youth. Employment Skills Development services are designed to:

- Be individually tailored to directly address the child/youth's employment goals as identified in the needs assessment and included in the person-centered plan. If the child/youth has received a Career Assessment that has determined that the child/youth is in need of acquiring particular skills in order to enhance their employability, those identified skills development areas must be addressed within the child/youth's person-centered plan and by the Employment Skills Development service.
- Enable each child/youth to attain the highest level of work in the most integrated setting and with the job matched to the child/youth's career goals, interests, strengths, priorities, abilities and capabilities, while

following applicable federal and State wage guidelines.

- Support acquisition of skills needed to obtain competitive, integrated employment in the community.
- Develop and teach general, translatable skills including, but not limited to, the ability to communicate effectively with supervisors, coworkers and customers; generally accepted community workplace conduct and dress; basic workplace requirements, like adherence to time and attendance expectations; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety; and training to enable the effective use of transportation resources.
- Provide and support the acquisition of skills necessary to enable the child/youth to obtain competitive, integrated work where the compensation for the child/youth is at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by children/youths without disabilities, which is considered to be the optimal outcome of Employment Skills Development services.

Support may be provided to children/youths for unpaid volunteer placement and training experiences, which may be provided in community-based settings. Skills development as a part of placement and training may occur as a one-to-one training experience or in a group setting in accordance with Department requirements.

If reliable transportation is not available through non-medical transportation benefits under the waiver or through natural supports, the Employment Skills Development service provider is responsible for providing (directly or through contractual arrangements) transportation between the child/youth's home and the employment site or meeting site except when the child/youth is in the custody of the State and SCDSS is responsible for providing the transportation, and after a determination that no more cost-effective means of transportation is available. The inclusion of transportation depends upon the needs of the child/youth as determined by an assessment, the wraparound facilitator/TCM and person-centered plan team. The need for transportation to and from the service site must be documented in the child/youth's person-centered plan. If a child/youth's need is not documented, then the service provider may only bill the rate built without transportation to and from the service site. All providers of transportation services are responsible to ensure the health, welfare and safety of the children/youths to whom they render service.

Employment Skills Development may be provided in a variety of community-based settings outside of the child/youth's home. Children/youths receiving Employment Skills Development services must have measureable employment-related goals in their person-centered plan.

Services must be delivered in a manner that supports the child/youth's communication needs including, but not limited to, age appropriate communication, translation services for children/youths who are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider's understanding and use of communication devices used by the child/youth.

If the child/youth receives wraparound services, this service includes implementation of the person-centered plan and, if necessary, the crisis support plan. The service includes collecting and recording the data necessary to support the review of the person-centered plan, and the crisis support plan, as appropriate.

This service may be delivered in South Carolina and within 25 miles of the border in states contiguous to South Carolina.

The Employment Skills Development service provider must maintain documentation in accordance with Department requirements. The documentation must be available to the wraparound facilitator/TCM for monitoring at all times on an ongoing basis. The wraparound facilitator/TCM monitors on a quarterly basis to see if the objectives and outcomes are being met.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Employment Skills Development services may not be rendered under the waiver to a child/youth under a program funded by either the Rehabilitation Act of 1973 as amended or the Individuals with Disabilities Education Act (IDEA) or any other small business development resource available to the child/youth. Documentation in accordance with Department requirements must be maintained in the file by the wraparound facilitator/TCM and updated with each reauthorization to satisfy the State assurance that the service is not otherwise available to the child/youth under other federal programs.

Total hours for this service and Career Exploration and Assessment may not exceed 40 hours per week. It may not be offered on the same day as a Career Exploration and Assessment. Except as permitted in accordance with requirements contained in Department guidance, policy and regulations, this service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service.

Handicapped employment, as defined in Title 55, Chapter 2390, may not be funded through the waiver. Waiver funding is not available for the provision of Employment Skills Development (e.g., sheltered work performed in a facility) where children/youths are supervised in producing goods or performing services under contract to third parties.

Service Delivery Method *(check each that applies)*:	⌐	Participant-directed as specified in Appendix E	°	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	⌐	Legally Responsible Person	⌐	Relative	⌐ Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	⌐	Individual. List types:	°	Agency. List the types of agencies:
				Vocational Skills provider
				Employment Skills Development Provider

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Vocational Skills provider		Current State motor vehicle registration is required for all vehicles owned, leased and/or hired and used as a component of the Employment Skills Development service	• Comply with SCDHHS standards, including regulations, policies and procedures relating to provider qualifications and enrollment • Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service • Have a service location in South Carolina or within 25 miles of the border in a state contiguous to South Carolina • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies • Have Commercial General Liability insurance • Ensure that employees (direct,

			contracted or in a consulting capacity) have been trained to meet the unique needs of the child/youth; for example, communication, mobility and behavioral needs Individuals working for or contracted with agencies must meet the following standards: • Be at least 18 years of age • Associates degree and 60 hours of equivalent experience, or • Bachelor's or Master's degree, and • Have a minimum of 1 year of experience living or working with an child/youth with a disability or children/youths with support needs commensurate with children/youths served in the waiver or related educational experience • Comply with all SCDHHS standards including regulations, policies and procedures related to provider qualifications • Complete SCDHHS required training, including training on the child/youth's person-centered plan and the child/youth's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs • Pass a South Carolina criminal history background check, child abuse and neglect screen, motor vehicle screens, and excluded provider screen • Have a valid driver's license from South Carolina or a contiguous state if the operation of a vehicle is necessary to provide the service
Employment Skills Development Provider		Current State motor vehicle registration is required for all vehicles owned, leased and/or hired and used as a component of the Employment Skills Development service	• Comply with SCDHHS standards, including regulations, policies and procedures relating to provider qualifications and enrollment • Have or ensure automobile insurance for any automobiles owned, leased and/or hired when used as a component of the service • Have a service location in South Carolina or within 25 miles of the border in a state contiguous to South

			Carolina • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies • Have Commercial General Liability insurance • Ensure that employees (direct, contracted or in a consulting capacity) have been trained to meet the unique needs of the child/youth; for example, communication, mobility and behavioral needs Individuals working for or contracted with agencies must meet the following standards: • Be at least 18 years of age, • Associates degree and 60 hours of equivalent experience, or • Bachelor's or Master's degree, and • Have a minimum of 1 year of experience so required training, including training on the child/youth's person-centered plan and the child/youth's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs • Pass a South Carolina criminal history background check, child abuse and neglect screen, motor vehicle screens, and excluded provider screen • Have a valid driver's license from South Carolina or a contiguous state if the operation of a vehicle is necessary to provide the service

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Vocational Skills Provider	SCDHHS or designee	At least every 2 years and more frequently when deemed necessary by the Department
Employment skills development Service Provider	SCDHHS or designee	At least every 2 years and more frequently when deemed necessary by the Department

Service Specification	
HCBS Taxonomy **– Service Title: Community Psychiatric Support and Treatment (CPST)**	
Category 1:	Sub-Category 1:
10 - Other Mental Health and Behavioral Services	10090 - Other mental health and behavioral services
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

CPST includes time-limited goal-directed supports and solution-focused interventions intended to achieve identified person-centered goals or objectives as set forth in the child/youth's person-centered plan and CPST Individual person-centered plan. The services enable the child/youth to remain integrated in their community and ensure the health, welfare and safety of child/youth and family. Children/youth do not have previously had skills in order to receive this service (i.e., this service is habilitative in nature).

Comprehensive, community-based psychiatric treatment, habilitation, and support to persons with severe emotional disturbance and serious and persistent mental illness including initial and ongoing assessments, patient treatment coordination, psychiatric services, assistance with skilling building around housing and employment, psychoeducation, substance abuse services, and other services critical to a child/youth's ability to live successfully in the community. CPST target populations include children/youths who have not responded well to traditional outpatient mental health care and psychiatric rehabilitation services. The people served may have co-existing problems such as homelessness, substance abuse, and involvement with judicial system.

The following activities under CPST are designed to help persons with mental health, substance use disorder and/or co-occurring diagnosis to achieve stability and functional improvement in the following areas: daily living, finances, housing, education, employment, personal recovery and/or resilience, family and interpersonal relationships and community integration. CPST is designed to provide mobile treatment and rehabilitation services to children/youths who have difficulty engaging in site- based programs who can benefit from off-site rehabilitation or who have not been previously engaged in services, including those who had only partially benefited from traditional treatment or might benefit from more active involvement of their family of choice in their treatment. CPST includes supportive services furnished to the child/youth that transitions from residential and/or outpatient treatment services.

Service Components

The service may include the following components to meet the needs of the children/youths with mental health and/or a substance use diagnosis:

- Assist the child/youth and family members or other collaterals to identify strategies or treatment options associated with the child/youth's mental illness, with the goal of minimizing the negative effects of mental health, substance use disorder and/or co-occurring diagnosis symptoms or emotional disturbances or associated environmental stressors which interfere with the child/youth's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration
- Provide child/youth and their family supportive counseling, solution-focused interventions, emotional and behavioral management, and problem behavior analysis with the child/youth, with the goal of assisting the

child/youth with social, interpersonal, self-care, daily living, and independent living skills to restore stability, to support functional gains and to adapt to community living

- Facilitate participation in and utilization of strengths based planning and treatments which include assisting the child/youth and family members or other collaterals with identifying strengths and needs, resources, natural supports, and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their mental illness
- Assist the child/youth with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the child/youth and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or as appropriate, seeking other supports to restore stability and functioning
- Provide ongoing rehabilitation support for children/youths pursuing employment, housing, or education goals. Assist the child/youth with independent living skills to promote recovery and growth specific to managing their own home including managing their money, medications, and using community resources and other self-care requirements
- Implement interventions using evidence-based and best practice techniques, drawn from cognitive-behavioral therapy and other evidence-based psychotherapeutic interventions that ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom interference with daily activities.
- Implement interventions provided to children/youths by a behavioral health provider in the home or community to help children/youths learn and practice the skills consistent with the interventions identified through other activities under CPST and needed to support overall wellness and independent living abilities. These services would support children/youths in continuing to enhance pro-social life skills. The interventions provide onsite modeling, training, cueing, and/or supervision to assist the child/youth with a mental health, substance use disorder and/or co-occurring diagnosis in developing maximum independent functioning in community living activities. As necessary, the interventions may include assistance in completing Activities of Daily Living and Instrumental Activities of Daily Living (ADLs and IADLs). These services also include assistance with medication administration and the performance of health-related tasks to the extent State law permits.

Modality

CPST is a face-to-face intervention, telephonic, or other interactive method of communication with the child/youth, family or other collateral contacts. CPST includes the modalities of the following SAMHSA evidence-based practices: Multisystemic Therapy (MST), Functional Family Therapy (FFT), Dialectical Behavior Therapy (DBT), Homebuilders (HB), and Adolescent Community Reinforcement Approach (A-CRA).

Setting

- Services must be offered in the setting best suited for desired outcomes, including home or other community-based setting.
- Off site.
- Setting may include the provider's office as needed, but this service is designed to be provided in the community.
- Groups should not exceed 6-8 children.

CPST services are intended to help engage children/youths with mental health and/or a co-occurring substance use diagnosis who are unable to receive site-based care or who may benefit from community based services including those who had only partially benefited from traditional treatment or might benefit from more active involvement of their family in their treatment. In addition, this service is intended for children/youths who are being discharged from inpatient units, jail or prisons, and with a history of non-engagement in services, transitioning from crisis services, and for people who have disengaged from care. Evidence-based practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by the State Medicaid Agency or its designee.

Admission criteria

- Must be certified by the psychiatric prescriber.
- Severe and Persistent Mental Illness that seriously impairs a person's ability to live in the community.

- Priority is for people with Schizophrenia, other psychotic disorders, Bipolar Disorder, or Major Depressive Disorder.
- Must have primary MH diagnosis or co-occurring disorder (COD).
- Individuals with only SA/IDD, brain injury, personality disorder are not intended recipients
- May have repeated hospitalizations with SA issues.
- Must have at least one of the following:
  - Difficulty performing daily tasks for basic adult functioning in the community (e.g. personal business; obtaining medical, legal, and housing services; recognizing and avoiding common dangers to self and possessions; meeting nutritional needs; maintaining personal hygiene).
  - Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g. household meal preparation, washing clothes, budgeting or child care tasks).
  - Significant difficulty maintaining a safe living situation (e.g. repeated evictions or loss of housing)
  - Continuous high-service needs as demonstrated by at least one of the following:
    - Co-occurring substance use and SPMI or SMI of significant duration, e.g., greater than six months.
    - High risk or recent history of criminal justice involvement, e.g., arrest and incarceration.
    - Difficulty effectively utilizing traditional office-based outpatient services or other less-intensive community-based programs, e.g., child/youth fails to progress, drops out of service.
- Requests for discharge from services shall occur when an child/youth:
  - Has successfully reached individually-established goals (i.e. demonstrates an ability to function in all major role areas such as work, social, self-care) for discharge and when the child/youth and program staff mutually agrees to the transition to less intensive services;
  - Moves outside the geographic area of team responsibility. In such cases, the team shall arrange for transfer of mental health service responsibility to a program or another provider wherever the child/youth is moving. The team shall maintain contact with the child/youth until this service transfer is complete;
  - Declines or refuses services and requests discharge, despite the team's documented best efforts to utilize appropriate engagement techniques to develop a mutually acceptable person directed person-centered plan with the child/youth.
- Prior to discharge from services, the State shall approve and/or request further information to review the circumstances, the clinical situation, the risk factors, and attempted strategies to engage the child/youth prior to the discharge of a child/youth from services.
- In addition to the discharge criteria listed above based on mutual agreement between the child/youth, CPST staff, an child/youth discharge may also be facilitated due to any one of the following circumstances:
  - Death.
  - Inability to locate the child/youth despite documented active outreach efforts by the team for a period of ninety (90) continuous days.
  - Incarceration of ninety (90) days or more.
  - Hospitalization or nursing facility care where it has been determined, based on mutual agreement by the hospital or nursing facility treatment team and the team with approval of plan by the State, that the child/youth is not appropriate for discharge from the hospital or nursing facility for a prolonged period of time.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Categorically needy *(specify limits):*
Community treatment for eligible children/youths can continue as long as needed, within the limits, based on the child/youth's needs. The intent of this service is to eventually transfer the care to an office clinical setting as needed by the child/youth.

The total combined hours for CPST and Psychosocial Rehabilitation (PSR) and are limited to no more than a total of 6 hours

a day.

Decisions about how to balance caseloads are left to the provider agencies as they see appropriate to ensuring quality of care and maintaining acceptable performance outcomes.

Services may be provided at a community-based office, in the community, or in the child/youth's place of residence as outlined in the person-centered plan. Components that are not provided to, or directed exclusively toward the treatment of, the Medicaid eligible child/youth are not eligible for Medicaid reimbursement.

Service Delivery Method *(check each that applies)*:	⌐	Child/youth-directed as specified in Appendix E	°	Provider managed	
Specify whether the service may be provided by *(check each that applies):*	⌐	Legally Responsible Person	⌐	Relative	⌐ Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	⌐	Individual. List types:	°	Agency. List the types of agencies:
				Rehabilitation Provider entities
				Substance Use Disorder (SUD) treatment program or a co-occurring (SUD with mental health disorder) treatment program
				Multi-systemic Therapy (MST) Team
				Functional Family Therapy (FFT) Team
				Dialectical Behavior Therapy (DBT) Team
				Homebuilders (HB) Team
				Adolescent Community Reinforcement Approach (A-CRA

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Rehabilitation Provider entities			• Comply with all SCDHHS standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications and enrollment. • New applicants and providers seeking revalidation shall be subject to a pre and post site visit. • Private providers must be accredited by the Commission

			on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), the Joint Commission in Behavioral Health Services, or Healthcare Facilities Accreditation Program (HFAP). • Licensed Practitioner of the Healing Arts or medical staff providing supervision to unlicensed HCBS staff must be licensed or registered with the State where the business is located • The applicant must have a business license from the state and/or municipality or county where the service is provided • Physical or primary business site must be located in the SC Medicaid Service Area (SCMSA) • Proof of General Liability insurance coverage worth at a minimum of $600,000 • Proof of Worker's Compensation insurance, if five or more full time personnel staff • Accept the reimbursement rates established by Medicaid. Designation by SCDHHS as a rehabilitation provider entity including compliance with minimum State training requirements. Rehabilitation provider entities may provide any component of the services listed and must employ/contract and utilize the qualified HCBS providers necessary to maintain children/youths in the community including CPST specialists. CPST specialists in rehabilitation provider entity: Must be

			determined to be a clinician under State regulations meaning a person with a doctoral or master's degree in psychology, counseling, social work, nursing, rehabilitation or related field from an accredited college or university. Anyone providing SUD services must be certified by South Carolina Department of Alcohol and Other Drug Abuse Services (SCDAODAS) in addition to any required scope of practice license required for the facility or agency to practice in the State of South Carolina.
SUD treatment program or a co-occurring (SUD with mental health disorder) treatment program		Designated under South Carolina Act 301 of 1973	Comply with SCDHHS standards, including regulations, policies and procedures relating to provider qualifications and enrollment. SUD and co-occurring treatment programs providing CPST must employ professionals determined to be a clinician under State regulations meaning a person with a doctoral or master's degree in psychology, counseling, social work, nursing, rehabilitation or related field from an accredited college or university. Anyone providing SUD services must be certified by DAODAS in addition to any required scope of practice license required for the facility or agency to practice in the State of South Carolina.
Multi-systemic Therapy (MST) Team		Team holds a current national certification from MST. http://mstservices.com/	Designation by SCDHHS as a rehabilitation provider entity including compliance with minimum State training requirements. Rehabilitation provider entities may provide any component of the services listed and must employ/contract and utilize the qualified HCBS providers

			necessary to maintain children/youths in the community including CPST specialists. CPST specialists in rehabilitation provider entity: Must be determined to be a clinician under State regulations meaning a person with a doctoral or master's degree in psychology, counseling, social work, nursing, rehabilitation or related field from an accredited college or university.
Functional Family Therapy (FFT) Team		Team holds a current national certification from FFT. http://fftllc.com/about-fft-training/implementing-fft.html	Designation by SCDHHS as a rehabilitation provider entity including compliance with minimum State training requirements. Rehabilitation provider entities may provide any component of the services listed and must employ/contract and utilize the qualified HCBS providers necessary to maintain children/youths in the community including CPST specialists. CPST specialists in rehabilitation provider entity: Must be determined to be a clinician under State regulations meaning a person with a doctoral or master's degree in psychology, counseling, social work, nursing, rehabilitation or related field from an accredited college or university.
Dialectical Behavior Therapy (DBT) Team		Team holds a current national certification from **DBT**-Linehan Board of **Certification** (**DBT**-LBC) or Dialectical Behavior Therapy National Certification and Accreditation Association (DBTNCAA). http://behavioraltech.org/resources/certification.cfm https://www.dbtncaa.com/certification/	Designation by SCDHHS as a rehabilitation provider entity including compliance with minimum State training requirements. Rehabilitation provider entities may provide any component of the services listed and must employ/contract and utilize the qualified HCBS providers necessary to maintain

			children/youths in the community including CPST specialists. CPST specialists in rehabilitation provider entity: Must be determined to be a clinician under State regulations meaning a person with a doctoral or master's degree in psychology, counseling, social work, nursing, rehabilitation or related field from an accredited college or university.
Homebuilders (HB) Team		Team holds a current national certification from the Institute for Family Development. http://www.institutefamily.org/programs_IFPS.asp	Designation by SCDHHS as a rehabilitation provider entity including compliance with minimum State training requirements. Rehabilitation provider entities may provide any component of the services listed and must employ/contract and utilize the qualified HCBS providers necessary to maintain children/youths in the community including CPST specialists. CPST specialists in rehabilitation provider entity: Must be determined to be a clinician under State regulations meaning a person with a doctoral or master's degree in psychology, counseling, social work, nursing, rehabilitation or related field from an accredited college or university.
Adolescent Community Reinforcement Approach (A-CRA		Team holds A-CRA current national certification from Chestnut Health systems www.ebtx.chestnut.org/Treatments-and-Research/Treatments/A-CRA	Designation by SCDHHS as a rehabilitation provider entity including compliance with minimum State training requirements. Rehabilitation provider entities may provide any component of the services listed and must employ/contract and utilize the qualified HCBS providers necessary to maintain children/youths in the community

			including CPST specialists. CPST specialists in rehabilitation provider entity: Must be determined to be a clinician under State regulations meaning a person with a doctoral or master's degree in psychology, counseling, social work, nursing, rehabilitation or related field from an accredited college or university.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Rehabilitation Provider entities	SCDHHS or designee	Initially and annually thereafter
SUD treatment program or a co-occurring (SUD with mental health disorder) treatment program	SCDHHS or designee	Initially and annually thereafter
Multi-systemic Therapy (MST) Team	SCDHHS or designee	Initially and annually thereafter
Functional Family Therapy (FFT) Team	SCDHHS or designee	Initially and annually thereafter
Dialectical Behavior Therapy (DBT) Team	SCDHHS or designee	Initially and annually thereafter
Homebuilders (HB) Team	SCDHHS or designee	Initially and annually thereafter
Adolescent Community Reinforcement Approach (A-CRA	SCDHHS or designee	Initially and annually thereafter

Service Specification	
HCBS Taxonomy – **Service Title: Intensive Supported Employment (ISE)**	
Category 1:	Sub-Category 1:
03 – Supported Employment	03021 – Ongoing supported employment, individual
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

ISE are individualized, person-centered services providing supports to children/youths who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Children/youths in a competitive employment arrangement receiving ISE are compensated at or above the minimum wage and receive no less than the customary wage and level of benefits paid by the employer for the same or similar work performed by children/youths without disabilities. The outcome of this activity is documentation of the child/youth's stated career objective and a career plan used to guide child/youth employment support.

- Intensive supported employment: Services that consist of intensive supports that enable children/youths for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their disabilities, need supports to perform in a regular work setting.

- Transitional employment: Services that strengthen the child/youth's work record and work skills toward the goal of achieving assisted or unassisted competitive employment at or above the minimum wage paid by the competitive sector employer. This service is provided, instead of child/youth supported employment, only when the person specifically chooses this service and may only be provided by psychosocial certified providers or a Clubhouse program accredited by Clubhouse International.

- On-going supported employment: Conducted after a child/youth successfully obtains and becomes oriented to competitive and integrated employment. Ongoing follow-along support is available for an indefinite period as needed by the child/youth to maintain their paid employment position.

ISE services assist children/youths with co-occurring mental health and substance use disorders to obtain and keep competitive employment. These services consist of intensive supports that enable children/youths to obtain and keep competitive employment at or above the minimum wage. This service follows the evidence-based principles of the Individual Placement and Support (IPS) model. It consists of intensive supports that enable children/youths for whom competitive employment at or above the minimum wage is unlikely, absent the provision of supports, and who, because of their clinical and functional needs, require supports to perform in a regular work setting. Individual employment support services are individualized, person-centered services providing supports to children/youths who need ongoing support to learn a new job and maintain a job in a competitive employment or self-employment arrangement. Children/youths in a competitive employment arrangement receiving Intensive Supported Employment are compensated at or above the minimum wage and receive not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by children/youths without disabilities. The outcome of this activity is documentation of the

child/youth's stated career objective and a career plan used to guide child/youth employment support. ISE services are intensive supports for children/youths to perform in a regular work setting.

Components include:

- Assist the child/youth to locate a job or develop a job on behalf of the child/youth via the use of individualized placement and support services that include rapid job search including acquisition of hard and soft skills to retain employment, training and systematic instruction, as well as providing support for the job application process such as resume writing, interviewing and application submission
- Support the child/youth to establish or maintain self-employment, including home-based self-employment
- Provide ongoing job related discovery and assessment
- Provide job placement, systematic job development, job coaching, negotiation with prospective employers, job analysis, job carving (creating, modifying, or customizing a community-based job such that it can be successfully performed by an child/youth on supported employment) customize employment training and systematic instruction, benefits counseling support, training and planning, transportation, asset development and career advancement services, customized employment, and other workforce support services.
- Provide workforce support services including benefits counseling support (e.g., personalized benefits counseling that assists children/youths in obtaining personalized information about their government entitlements), training and planning, transportation navigation, asset development and career advancement services.

Intensive Supported Employment is a face-to-face intervention. This service is generally provided at an employment program but can be provided at a location of the child/youth's choosing including the workplace/job site based on child/youth need or the child/youth's residence.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:	⌐	Participant-directed as specified in Appendix E		°	Provider managed		
Specify whether the service may be provided by *(check each that applies):*	⌐	Legally Responsible Person	⌐	Relative	⌐	Legal Guardian	

Provider Specifications

Provider Category(s) *(check one or both)***:**	⌐	Individual. List types:	°	Agency. List the types of agencies:
				Individual Employment Support Services Provider Agency

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual Employment Support Services Provider Agency		Current State motor vehicle registration is required for all vehicles owned, leased, and/or hired and used as a	• Comply with SCDHHS standards, including regulations, policies and procedures relating to provider qualifications and enrollment • Have or ensure automobile insurance for any automobiles owned, leased,

		component of the Individual Employment Support Services service Certified by DMH as an team in fidelity with the evidence-based practice for Employment Supports	and/or hired when used as a component of the service • Have Worker's Compensation insurance in accordance with State statute and in accordance with Department policies • Have Commercial General Liability insurance • Ensure that employees (direct, contracted, or in a consulting capacity) have been trained to meet the unique needs of the child/youth; for example, communication, mobility, and behavioral needs • Comply with ISE fidelity. Individuals working for or contracted with agencies must meet the following standards: • Be at least 18 years of age, and • Bachelor's degree, and • Have a minimum of 1 year of experience living or working with an child/youth with a disability or support needs commensurate with the beneficiaries served in the waiver or related educational experience • Comply with all SCDHHS standards including regulations, policies, and procedures related to provider qualifications • Complete SCDHHS required training for the evidence-based practice, including training on the child/youth's person-centered plan and the child/youth's unique needs, which may include, but is not limited to, communication, mobility, and behavioral needs • Pass a South Carolina criminal history background check, child abuse and neglect screen, motor vehicle screens, and excluded provider screen • Have a valid driver's license if the operation of a vehicle is necessary to provide the service • Supervised by a team lead who has received specific evidence-based practice training.

Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Individual Employment Support Services Provider Agency	Department or Designee	Initially and annually (or more frequent based on service monitoring concerns)	

Service Specification	
HCBS Taxonomy – **Service Title: Respite**	
Category 1:	Sub-Category 1:
09 – Respite	09011 –Respite, out of home
Category 2:	Sub-Category 2:
09- Respite	09012 – Respite, in-home
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

Respite care includes services provided to beneficiaries unable to care for themselves furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the beneficiary. Respite may be provided in an emergency to prevent hospitalization. Respite provides planned or emergency short-term relief to a beneficiary's unpaid caregiver or principle caregiver who is unavailable to provide support. This service will be provided to meet the beneficiary's needs as determined by an assessment performed in accordance with department requirements and as outlined in the beneficiary's person-centered plan. Beneficiaries are encouraged to receive Respite in the most integrated and cost-effective settings appropriate to meet their respite needs.

Respite services may include the following activities:

- Assistance with the beneficiary's social interaction, use of natural supports and typical community services available to all people and participation in volunteer activities.
- Activities to improve the beneficiary's capacity to perform or assist with activities of daily living and instrumental activities of daily living.
- Onsite modeling of behavior, behavior support, intensive behavior episode intervention, training, cueing, and/or supervision.

Services must be delivered in a manner that supports the beneficiary's communication needs including, but not limited to, age appropriate communication, translation services for beneficiaries that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider's understanding, and use of communication devices used by the beneficiary. If the beneficiary is to receive respite on an ongoing basis, the care manager will monitor on a quarterly basis, as applicable, to see if the objectives and outcomes are being met.

Respite is a face-to-face service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

No longer than 1 week per episode, not to exceed a maximum of 21 days per year. Individual stays of greater than 72 hours require prior authorization. Individuals requiring crisis respite for longer periods may be evaluated on a child/youth basis and approved for greater length of stay based on medical necessity.

Respite services may not be billed at the same time as personal care services.

In certified and licensed settings where permissible and during respite hours in the child's home, medication may be administered during respite hours in the child's home by the respite worker. Medications, including controlled substances, medical supplies, and those items necessary for the rendering of first aid shall be properly managed in accordance with State, Federal, and local laws and regulations. Such management shall address the securing, storing, and administering of medications, medical supplies, first aid supplies, and biologicals, their disposal when discontinued or expired, and their disposition at discharge of a participant.

SCDHHS or its designee may authorize service request expectations above these limits on a case-by-case basis when it determines that:

1. No other service options are available to the member, including services provided through an informal support network;
2. The absence of the service would present a significant health and welfare risk to the child/youth; and

- Respite service provided in a certified residential care facility, Substance Use Disorder residential facility or Public or Private Child Service Entity is not utilized to replace or relocate a child/youth's primary residence. Room and board in Community Residential Group Home or Substance Use Disorder residential facility may be paid for by Medicaid for respite service only. In overnight settings of greater than 4 residents, between the hours of 7 am to 8 pm there shall be a minimum of one staff person on site for every five children/youth. Between the hours of 8 pm to 7 am there shall be a minimum of one staff person for every seven children/youth. At least one staff member must provide 24 hour awake supervision. The term "24 hour awake supervision" means that, during sleeping hours, a staff member is located in a position which allows him or her to observe any movement into or out of a child/youth's bedroom. On call staff must be available for emergencies and immediately accessible. The director or a designee shall be available at all times by cell phone.

Overnight settings offer a supportive home-like environment with a maximum preferred capacity of not to exceed 10 residents (fewer in rural areas), preferably in single rooms.

- The setting must be building and health and safety code compliant.
- Staffed and open 24 hours a day, seven days a week when a resident is present.
- Residents should be allowed to leave and return as needed, maintaining employment and other daily activities to the extent possible.

To the greatest extent possible, residents are encouraged to maintain contact with significant others, including family members, friends, and spouses. To facilitate this contact, residents may have visitors at any time that is convenient and practical for the resident as well as the operations overnight setting.

<u>EXCLUSIONS</u>:

- Diagnosis of dementia, organic brain disorder or traumatic brain injury
- Those with an acute medical condition requiring higher level of care
- At imminent risk to self or others that requires higher level of care
- Displays symptoms indicative of active engagement in substance use manifested in a physical dependence or results in aggressive or destructive behavior
- Does not have permanent housing or is homeless
- Is not willing or able to respect and follow the child/youth agreement during his/her stay
- Is not willing to sign necessary registration documentation
- Is not willing to participate in the wellness process during his/her stay

Medical Necessity Criteria include:

- The service is recommended by the wraparound facilitator/TCM and the child/youth in collaboration, and the service is included in the child/youth's person-centered plan; AND
- There are emotional and/or behavioral problems which stress the ability of the caregiver or child/youth to provide for the child/youth's needs in the home thus putting the child/youth at risk of requiring a more intensive level of care (e.g., strained family relationships; exhaustion in caregiver; caregiver struggles to meet other work/family responsibilities or lacks enough time to care for self needs; increased symptoms of mental illness or substance use, such as psychotic thinking, sleeplessness, or self-injurious behavior) OR the primary caregiver has a time limited situation that necessitates assistance in providing care for the child/youth (e.g., caregiver is experiencing an acute medical problem, caregiver must attend to a family crisis); AND
- The absence of the service would present a significant health and welfare risk to the child/youth (e.g., child/youth has a seizure disorder, child/youth needs assistance with medication administration, child/youth has difficulty appropriately regulating water intake)
- No other means of temporary care exists; AND
- The frequency and intensity of the service aligns with the unique situation of the child/youth and/or caregiver. Examples include:
  - A caregiver requests respite for a particular weekend so he can have a break and visit family members out of state.
  - A child/youth has a goal on her person-centered plan to appropriately limit her water intake, since it has led to electrolyte imbalances numerous times in the past, and agrees that she continues to need support in order to achieve that goal. As a result, she and her sister (who she lives with) have identified the need for pre-planned respite services one afternoon each month so the sister can go to a movie or shopping alone.
  - A caregiver has identified the immediate need for respite services for up to a week because the child/youth has been awake most of the night for the last three nights, resulting in the caregiver being awake as well and unable to go to work. The caregiver believes the child/youth's mood and sleep cycle will normalize in about a week, as it has done many times before, but respite allows the child/youth to avoid a higher level of care and provides a needed break for the caregiver.

Service Delivery Method *(check each that applies)*:	☐	Child/youth-directed as specified in Appendix E	☐	Provider managed

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative	☐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☐	Agency. List the types of agencies:
				Certified Respite Caregiver
				In Home Caregiver
				Home Health Agency
				Supportive Housing Agency
				Public or Private Child Service Entity
				Substance Use Disorder residential facility
				Group homes, if not on an IMD campus

		Rehabilitative Behavioral Health Services (RBHS) Providers

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Certified Respite Caregiver	SC Code Ann. §44-20-10 thru 44-20-5000 (Supp 2008); §44-20-710 (Supp 2008) for facilities and 44-21-10 for in-home respite Respite Licensing Standards are by SCSCDHEC, SCDDSN, or SCDSS according to the location the respite care is being provided.		• Comply with SCDHHS standards, including regulations, policies and procedures relating to provider qualifications and enrollment • Respite Care Workers must meet minimum qualifications as stipulated in SC Respite Program Standards. • If respite location is in a private residence the Respite Care Worker receives certification through SCDDSN as a Home Support Caregiver.
In-home Care Provider	State Business License or 501(c)(3) status; and In-home Care Provider license per State regulation 61-122 from SCSCDHEC and SC code of law 44-70-10 thru 44-70-80. Licensed staff must adhere to the DLLR practice acts for their discipline.	N/A	• Comply with SCDHHS standards, including regulations, policies and procedures relating to provider qualifications and enrollment. • Complete and ensure employees complete SCDHHS-required training, including training on the child/youth's person-centered plan and the child/youth's unique and/or disability-specific needs, which may include, but is not limited to, communication, mobility, and behavioral needs. Individuals employed by providers must: a• Be at least 18 years of age. b• Pass a South Carolina criminal history background check, child abuse and neglect screen, motor vehicle screens, and excluded provider screen. c• In the case of direct care personnel, possess certification through successful completion of training program as required by the SCDHHS.
Home Health Agency	State Business License or 501 (c)(3) status; and State Home Health Agency License per State regulation	Certified to participate under Title XVII (Medicare) by	• Comply with SCDHHS standards, including regulations, policies and procedures relating to provider qualifications and enrollment.

	61-77. Licensed staff must adhere to the LLR practice acts for their discipline. Also guided by S.C. Code Ann. § 44-69-10 through § 44-69-100.	SCSCDHEC. Meet the conditions governing participation as certified by SCSCDHEC, and have an approved Certificate of Need (CON) (under SCSCDHEC Regulation # 61-15 and SC Code of Law 44-7-110.	• Complete and ensure employees complete SCDHHS-required training, including training on the child/youth's person-centered plan and the child/youth's unique and/or disability-specific needs, which may include, but is not limited to, communication, mobility, and behavioral needs. Individuals employed by providers must: a• Be at least 18 years of age. b• Pass a South Carolina criminal history background check, child abuse and neglect screen, motor vehicle screen, and excluded provider screen. c• In the case of direct care personnel, possess certification through successful completion of training program as required by the SCDHHS.
Supportive Housing Agency		Certification	The agency must maintain staffing necessary for the health and welfare of the transition age youth. The staff must meet the qualifications and training below. • Comply with SCDHHS standards, including regulations, policies and procedures relating to provider qualifications and enrollment. • Complete and ensure employees complete SCDHHS-required training, including training on the child/youth's person-centered plan and the child/youth's unique and/or disability-specific needs, which may include, but is not limited to, communication, mobility, and behavioral needs. • Organization must be able to document three years of experience in providing services to persons with severe mental illness. • Comply with and meet all standards as applied through each phase of the standard, annual Department performed monitoring process.

			• Ensure 24-hour access to personnel (via direct employees or a contract) for response to emergency situations that are related to the residential supports or other waiver services. Employees must: • Must be at least 18 years old, and have a high school diploma or equivalent. • Pass a South Carolina criminal history background check, child abuse and neglect screen, motor vehicle screen, and excluded provider screen • In the case of direct care personnel, possess certification through successful completion of training program as required by the SCDHHS. If providing nursing care, must have qualifications required under State Nurse Practice Act (i.e. RN or LPN). • Have a valid driver's license if the operation of a vehicle is necessary to provide the service. All supervised housing staff must complete the training on the following topics: • CPR • First Aid • Introduction to Community-Based Residential Services for Direct Care Staff • Air and Blood Borne Pathogens • Non-Physical Crisis De-Escalation, Crisis Management and Debriefing • Proper Techniques to address Challenging Behavior and Proper Contingency Management • Principles of Psychiatric Rehabilitation • Motivational Interviewing for Co-Occurring Disorders • Basics of Counseling • Recovery Oriented Service Delivery & Documentation

			• What is Peer Support • Rights and Responsibilities of Individuals receiving Mental Health services • Cultural Competence and Diversity • Prevention/Intervention and Recovery/Resiliency Strategies • Behavioral Health/SUDs and Associated Medical Care and Conditions • HIPAA and Confidentiality • Grief, Loss, and Death Notification Procedures • Applied Suicide Intervention Skills • Introduction to Human Needs, Values, Guiding Principles, and Effective Teaching Strategies • Environmental Emergencies: Mitigation, Preparation, and Responding • Basic Health and Medications • Advanced Health and Medications • Nutrition: Food Preparation, Food Storage, Healthy Diet, and Positive Health • Assessing mobile crisis need
Public or Private Child Service Entity	The provider must have a current SCDSS license as a foster care placement institution In addition, foster homes must be individually licensed by SCDSS as foster care homes. S.C. Code Ann. §63-11-10 thru 63-11-790 (Supp 2008).		• Comply with SCDHHS standards, including regulations, policies and procedures relating to provider qualifications and enrollment • Complete and ensure employees complete SCDHHS-required training, including training on the child/youth's person-centered plan and the child/youth's unique and/or disability-specific needs, which may include, but is not limited to, communication, mobility, and behavioral needs. • The provider must be in good standing per State Medicaid regulations. The foster home parents and agency staff must be licensed and/or credentialed per State Medicaid policy. • All agencies who provide respite

			services must ensure that all employees participate in required annual training per waiver and State Medicaid policy. Individuals employed by providers must: a• Be at least 21 years of age. b• Pass a South Carolina criminal history background check, child abuse and neglect screen, motor vehicle screen, and excluded provider screen. c• In the case of direct care personnel, possess certification through successful completion of training program as required by the SCDHHS. Supervisors of respite staff must meet the following requirements: • A registered nurse licensed to practice in South Carolina and have at least three years of experience performing clinical or case work activities; or have meet one of the supervisor criteria listed below for in-home. Respite provided in the child's home: Respite staff requirements: An individual who provides respite services, in the participant's home, must be employed through an enrolled respite provider and successfully complete all required training. A respite staff must meet the following requirements: • Be at least twenty one years of age or older; • Have knowledge of the needs of children and be capable of meeting the needs of children in the waiver; • Be capable of handling an emergency situation; • Respite staff must take a minimum of fourteen (14) hours of appropriate Respite care training and expected standards

			of care; • A minimum of three written letters of reference shall be initially obtained prior to the Respite worker providing respite services to a child in the child's home. References should have known the applicants three years prior to the application and, unless specifically requested, should not be related to the applicants. Supervisors of Respite staff who provide services in the child's home must ensure that all employees participate in all required training. Supervisors of Respite staff must meet one of the following requirements: • A master's degree in social work, psychology, counseling, special education, or in a closely related field • A baccalaureate degree in social work, psychology, counseling, special education, or in a closely related field and have at least one year of experience performing clinical or case work activities; or • A baccalaureate degree in an unrelated field of study and at least three years of experience performing clinical or case work activities
SUD residential facilities	Licensed by SCSCDHEC per 61-93 and S.C. Code Ann. § 44-7-260(A) Licensed staff must adhere to the Department of LLR for the practice act for his discipline.	Certified by DAODAS	Certified by DAODAS as either a SUD residential or detoxification program and be authorized to provide a set number of licensed beds.
Non-IMD Group Homes	SC Code, Sec. 44-7-260 DHEC Reg. #61-84		Group Homes may have no more than 16 beds. The agency must maintain a staffing ratio consistent number of children in

			the home necessary to keep the children safe. An adult staff member must be awake and present at all times in the facility. If cameras are used, the staff must monitor the cameras and be within walking distance of the children. The staff must meet the following qualifications and training: Availability of a clinician (on call 24/7 for emergencies and staff consultation) with a doctoral or master's degree in clinical or counseling psychology, mental health nursing, clinical social work, vocational/psychiatric rehabilitation or education from an accredited college or university; or a registered nurse with certification in mental health nursing from the American Nurses Association. . The home will also have access to a physician after hours for emergencies. Residence Manager - Responsible for the operation of the group home and responsible for the supervision of residents' treatment plans. The qualifications of the Residence Manager must be at least a Bachelor's degree. Residential Service Assistants - A person who has a high school diploma, GED, or CNA. The service provider shall comply with criminal background check and drug testing laws. The service provider shall maintain a current personnel policies and procedures manual that sets forth grounds for termination, adequately supports sound resident care and is made readily available to the program's staff in each home. The service provider shall comply with the provisions of such manual. . • Training in risk assessment of dangerousness and interventions

			aimed at reducing such risk, including training in managing difficult behaviors, in the implementation of de-escalation techniques, and in self-defense techniques to prevent harm from violent behaviors *Note:Training in the use of alternatives to seclusion and restraint is required* • A complete course in medications used in the treatment of mental illness including the medications' effects, side effects, and adverse effects (sometimes life threatening) used alone or in combination with other prescription and non-prescription medication and alcoholic or caffeinated beverages; • Training in the common types of mental illness including signs and symptoms of schizophrenia, mood and personality disorders and indications of deterioration of an individual's mental condition; • Training in basic first aid, including basic CPR training and fire safety and evacuation procedures; • An explanation of the rights of children with psychiatric disabilities in residential care in South Carolina; • Expectations for confidentiality and ethical behavior towards residents who will reside in the group home; • Policies and procedures that apply to a group home on both a daily and emergency basis; • Health care, sanitation, and safe handling of food; • Orientation to situational counseling, de-escalation and mediation techniques, stress management and social interaction, and • A plan for the continuing

			education and development of staff including but not limited to: A protocol and training for all direct care staff on the medication protocols in place for the home (i.e., a nurse or pharmacy sets up the medication and the medications are in daily packages in a locked cabinet. The staff's role is to make sure the right medications are taken at the right time by observing the youth, but not to "administer" them. A nurse verifies that the medications are taken daily.) • Training for all direct care staff on any side effects of medications given to house residents, to promote monitoring for symptoms like excessive thirst and other issues that reflect the need for some intervention. • Training on basic physical health and symptoms to monitor for when a child/youth is in a residential program. A service provider need not require training in discrete areas in which the staff person has demonstrated competency through satisfactory job performance or previous experience to the satisfaction of the service provider and the Department.
Rehabilitative Behavioral Health Services (RBHS) Providers			Meet requirement for South Carolina RBHS including any licensure/certification and appropriate standards of conduct by means of evaluation, education, examination, and disciplinary action regarding the laws and standards of their profession as promulgated by the South Carolina Code of Laws and established and enforced by the South Carolina Department of Labor Licensing and Regulation. Professionals, who have received appropriate education, experience and have passed prerequisite examinations as required by the applicable state laws and

			licensing/certification board and additional requirements as may be further established by DHHS, may qualify to provide Rehabilitative behavioral health services. The presence of licensure/certification means the established licensing board in accordance with SC Code of Laws has granted the authorization to practice in the state. Licensed professionals must maintain a current license and/or certification from the appropriate authority to practice in the State of South Carolina and must be operating within their scope of practice. The following professionals possessing the required education and experience are considered clinical professionals/paraprofessionals and may provide Medicaid Rehabilitative behavioral health services in accordance with SC State Law: Staff qualifications include the following: • Peer Support Specialist (PSS) qualified under the State Plan • Substance Abuse Specialist • Mental Health Specialist • Child Service Professional • Behavior Analyst (Bachelor's level) • Licensed Bachelor of Social Work (LBSW) • Licensed Professional Counselor (LPC) • Licensed Practical Nurse (LPN) • Registered Nurse (RN) Supervision Requirements Rehabilitative behavioral health services provided by licensed/certified professionals must follow supervision requirements as required by SC State Law for each respective profession. Rehabilitative behavioral health services provided by any unlicensed/uncertified

			professional must be supervised by a master's level clinical professional or licensed practitioner of the healing arts (LPHA). Substance Abuse Professionals who are in the process of becoming credentialed must be supervised by a Certified Substance Abuse Professional or LPHA. The following licensed professionals are considered a LPHA: psychiatrist, physician, psychologist, physician's assistant, advanced practice registered nurse, registered nurse with a Master's degree in psychiatric nursing, licensed independent social worker -clinical practice, licensed master social worker, licensed marriage and family therapist and licensed professional counselor.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Certified Respite Caregiver	SCDHHS or designee	Initially and annually thereafter
In Home Caregiver	SCDHHS or designee	Initially and annually thereafter
Home Health Agency	SCDHHS or designee	Initially and annually thereafter
Supportive Housing Agency	SCDHHS or designee	Initially and annually thereafter
Public or Private Child Service Entity	SCDHHS or designee	Initially and bi-annually thereafter
Substance Use Disorder residential facility	SCDHHS or designee	Initially and annually (or more frequent based on service monitoring concerns)
Group Homes	SCDHHS or designee	Initially and annually thereafter
RBHS Providers	SCDHHS or designee	Initially and annually thereafter

Service Specification	
HCBS Taxonomy – **Service Title: Non-medical Transportation**	
Category 1:	Sub-Category 1:
15 – Non-medical Transportation	15010 – Non-medical transportation
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition (Scope)**:**

Non-medical Transportation services are offered, in addition to any medical transportation furnished under the 42 CFR 440.17(a) in the State Plan. Non-medical Transportation services are necessary, as specified by the person-centered plan, to enable children/youths to gain access to authorized home and community based services that enable them to integrate more fully into the community and ensure the health, welfare, and safety of the child/youth.

This service is provided to meet the child/youth's needs as determined by an assessment performed in accordance with Department requirements and as outlined in the child/youth's person-centered plan.

Transportation services consist of:

- Transportation (Mile)
  This Transportation service is delivered by providers, family members, and other qualified, licensed drivers. Transportation (Mile) is used to reimburse the owner of the vehicle or other qualified, licensed driver who transports the child/youth to and from services and resources related to outcomes specified in the child/youth's person-centered plan. The unit of service is one mile. Mileage can be paid round trip. A round trip is defined as from the point of first pickup to the service destination and the return distance to the point of origin.

  When transportation (mile) is provided to more than one child/youth at a time, the provider divides the shared miles equitably among the children/youths to whom transportation is provided. The provider is required (or it is the legal employer's responsibility under the Vendor Fiscal/Employer Agent (FMS) model) to track mileage, allocate a portion to each child/youth, and provide that information to the wraparound facilitator/TCM for inclusion in the child/youth's person-centered plan.

  Services must be delivered in a manner that supports the child/youth's communication needs including, but not limited to, age appropriate communication, translation services for children/youths that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider's understanding and use of communication devices used by the child/youth.

- Public Transportation
  The utilization of public transportation promotes self-determination and is made available to children/youths as a cost-effective means of accessing services and activities. This service provides payment for the child/youth's use of public transportation.

Transportation services under the 1915(c) program are offered in accordance with the child/youth's person-centered plan. Whenever possible and as determined through the person-centered planning process, family, neighbors, friends, carpools, coworkers, or community agencies which can provide this service without charge must be utilized.

Transportation services are delivered through a transportation broker who arranges and/or provide services pursuant to the person-centered plan.

Such transportation may also include public transportation. The utilization of public transportation promotes self-determination and is made available to children/youths as a cost-effective means of accessing services and activities. This service provides payment for the child/youth's use of public transportation to access employment.

The wraparound facilitator/TCM monitors this service quarterly and provides ongoing assistance to the child/youth to identify alternative community-based sources of transportation.

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.) or any other source.

Transportation services provided through the waiver are not used for obtaining State Plan services. The child/youth's person-centered plan must document the need for those non-medical transportation services that are not covered under the medical assistance transportation program.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Medical necessity criteria include the following:

- The service is recommended by the wraparound facilitator/TCM and the child/youth in collaboration, and the service is included in the child/youth's person-centered plan; OR
- The service is directly related to a goal on the child/youth's person-centered plan related to community integration and/or employment;

AND the following criteria must be met:

- The service is needed to allow the child/youth the best opportunity to remain in the community, AND
- The child/youth has no other means of transportation available (e.g., family, neighbors, friends, carpools, co-workers, natural supports, community agencies); AND
- The service is not intended to meet the general transportation needs of the child/youth in an ongoing fashion; AND
- The service is not provided during the performance of the child/youth's paid employment; AND
- The frequency and intensity of the service aligns with the unique needs of the child/youth. Examples include:
    - A child/youth identifies the need for public transportation support to help her get to and from her new job she obtained through supported employment efforts.
    - A child/youth has established a goal to increase his social support network and needs non-medical transportation to a peer-operated program two days per week for the next three months.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Categorically Needy (specify limits):

The wraparound facilitator/TCM monitors this service quarterly and provides ongoing assistance to the child/youth to identify alternative community-based sources of transportation.

Replacement cards for lost or stolen cards or passes are to be approved by the wraparound facilitator/TCM. Children/youths must report lost or stolen card/pass and have written documentation to present.

The type and amount of waiver transportation must be included in the approved person-centered plan. Non-medical transportation services may only be included in the person-centered plan after an individualized determination that the method is the most cost-effective manner to provide needed transportation services to the child/youth, and that all other non-Medicaid sources of transportation which can provide this service without charge (such as family, neighbors, friends, community agencies), have been exhausted.

Services that cannot be claimed as HCBS transportation services include:

1. Services not authorized by the person-centered plan.
2. Trips that have no specified purpose or destination.
3. Trips for family, provider, or staff convenience.
4. Transportation provided by the child/youth.
5. Transportation provided by the child/youth's spouse.
6. Transportation provided by the biological, step, adoptive parents of the child/youth, legal guardian, or foster parent, when the child/youth is a minor.
7. Transportation provided by a family member, including but not limited to siblings, grandparents, cousins, aunts or uncles, or any individual related by blood or marriage whose close association with the participant is the equivalent of a family relationship, or any spouse or domestic partner of a listed individual.
8. Trips when the child/youth is not in the vehicle.
9. Transportation claimed for more than one child/youth per vehicle at the same time or for the same miles, except public transportation. Note: When transportation (mile) is provided to more than one child/youth at a time, the provider divides the shared miles equitably among the children/youths to whom transportation is provided so that transportation is not claimed for more than one child/youth per vehicle at the same time for the same miles.
10. Transportation outside the State of South Carolina, unless:
11. The transportation is provided to access the nearest available medical or therapeutic service.
12. Advance written approval is given by the wraparound facilitator/TCM.
13. Services that are mandated to be provided by the public schools as specified in the child/youth's IEP pursuant to the Individuals with Disabilities Education Act.
14. Services that are mandated to be provided by Vocational Rehabilitation as specified in the child/youth's IEP pursuant to the Rehabilitation Act of 1973.

Non-medical Transportation does not pay for vehicle purchases, rentals, modifications, or repairs.

Non-medical Transportation cannot be billed at the same time a provider is providing a service with transportation built into the rate (e.g., if a supported employment rate includes transportation then non-medical transportation cannot be billed for supported employment trips – instead the supported employment provider would be financially responsible for the transportation).

Except as permitted in accordance with requirements contained in Department guidance, policy, and regulations, this service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service. This service may not be included on the same person-centered plan as Community Based Residential Alternatives/Assisted Living/ ICM, as the providers of these services are responsible for transportation and in these situations the cost of transportation is built into the rate.

A child/youth's person-centered plan may authorize no more than $2,000 per calendar year for both public and mile reimbursement combined.

Children in foster care are not eligible for this 1915(c) service per 42 CFR 441.18(c).

The unit of service is one mile. Mileage can be paid round trip. A round trip is defined as from the point of first pickup to the service destination and the return distance to the point of origin. When transportation (mile) is provided to more than one child/youth at a time, the provider divides the shared miles equitably among the children/youths to whom transportation is provided. The provider is required to track mileage, allocate a portion to each child/youth, and provide that information to the wraparound facilitator/TCM for inclusion in the child/youth's person-centered plan.

The wraparound facilitator/TCM must ensure that the provider maintains documentation and that the wraparound facilitator/TCM monitors the services on an on-going basis to ensure that the health and welfare of the child/youth is met and the person-centered plan goals are achieved. The documentation must be available to the wraparound facilitator/TCM for monitoring at all times on an ongoing basis. Documentation in accordance with Department requirements must be maintained in the child/youth's file by the wraparound facilitator/TCM and updated with each reauthorization, as applicable.

Service Delivery Method *(check each that applies)*:	⌐	Participant-directed as specified in Appendix E	°	Provider managed		
Specify whether the service may be provided by *(check each that applies):*	⌐	Legally Responsible Person	⌐	Relative	⌐	Legal Guardian

Provider Specifications

Provider Category(s) *(check one or both)***:**	⌐	Individual. List types:	°	Agency. List the types of agencies:
				Transportation Broker

Provider Qualifications

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Transportation Broker	State Business License or 501 (c) (3) status	Broker	Contract with SCDHHS. All drivers possess a valid driver's license. All vehicles are properly registered and insured.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Transportation Broker	Department or Designee	Initially and annually (or more frequent based on service monitoring concerns)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

☐	**Not applicable –** Case management is not furnished as a distinct activity to waiver participants.
☒	**Applicable –** Case management is furnished as a distinct activity to waiver participants. Check each that applies:

☐	As a waiver service defined in Appendix C-3 (*do not complete C-1-c)*
☐	As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*
☐	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c*.
☐	As an administrative activity. *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

CFT/TCMs must meet conflict of interest and be certified as meeting high fidelity wraparound standards. CFT/TCMs must meet all other provider criteria as outlined in the Wraparound Facilitation service definition.

Appendix C-2: General Service Specifications

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services *(select one)*:

☐	**Yes**. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):
	All providers seeking enrollment to provide waiver services are required to receive State level criminal history checks through South Carolina Law Enforcement Division (SLED). The background checks must be updated annually. SCDHHS ensures such documentation has been obtained as a condition to enrollment. SCDHHS verifies annual updates have been obtained during annual QA reviews. This investigation is the meaning of the following statement throughout this waiver: "pass a South Carolina criminal history background check".
☒	**No**. Criminal history and/or background investigations are not required.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry *(select one)*:

☐	**Yes**. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
	The Department of Social Services (SCDSS) maintains an abuse registry for the State. All providers seeking enrollment to provide waiver services are required to conduct abuse registry screening on employees. SCDHHS ensures such documentation has been obtained as a condition to enrollment. Providers are responsible for ensuring that all employees, contracted workers and volunteers who have direct contact with youth in the waiver have been screened. The screenings must be updated annually. SCDHHS verifies annual updates have been obtained during annual QA reviews. This investigation is the meaning of the following statement throughout the waiver: "pass a child abuse and neglect screen".
☒	**No**. The State does not conduct abuse registry screening.

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one*:

☐	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*
☒	**Yes**. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Complete Items C-2-c.i –c.iii.*

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

iii. Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following *(check each that applies)*:

Standard	Topic Addressed
Admission policies	⌐
Physical environment	⌐
Sanitation	⌐
Safety	⌐
Staff : resident ratios	⌐
Staff training and qualifications	⌐
Staff supervision	⌐
Resident rights	⌐
Medication administration	⌐
Use of restrictive interventions	⌐
Incident reporting	⌐
Provision of or arrangement for necessary health services	⌐

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participant is assured in the standard area(s) not addressed:

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

¬	**No**. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
⊣H	**Yes**. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

¬	**The State does not make payment to relatives/legal guardians for furnishing waiver services.**
⊣H	**The State makes payment to relatives/legal guardians under *specific circumstances* and only when the relative/guardian is qualified to furnish services**. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*
⊣H	**Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.** Specify the controls that are employed to ensure that payments are made only for services rendered.
⊣H	Other policy. *Specify*:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Any willing and qualified provider has the opportunity to enroll as a Medicaid provider of waiver services. All potential providers are required to execute a Medicaid provider agreement and accept the State's payment for services rendered. Providers are also required to meet the provider qualifications, as set forth in this waiver.

Providers enroll utilizing the SCDHHS provider enrollment system to ensure that all required checks and credentials are obtained prior to providers being allowed to provide Medicaid and waiver services.

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	*Number and percent of new HCBS providers that meet initial enrollment requirements prior to providing waiver services.* *Numerator: Number of new providers that meet initial enrollment requirements prior to providing waiver services.* *Denominator: Total number of new providers enrolled*
Data Source *(Select one) (Several options are listed in the on-line application):* ***Record reviews, off-site***	

If 'Other' is selected, specify:			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⌙ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⊏ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⊏ *Representative Sample; Confidence Interval =95%*
	⌙ *Other Specify:*	⊏ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*	
			⌙ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⊏ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other Specify:*	⊏ *Annually*
	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

Performance Measure:	*Number and percent of HCBS providers that continue to meet enrollment requirements at re-enrollment or review.* *Numerator: Number of HCBS providers that continue to meet enrollment*

	requirements at reenrollment or review. *Denominator: Total number of HCBS providers at reenrollment or review.*
Data Source** (Select one) (Several options are listed in the on-line application):* ***Other	
If 'Other' is selected, specify:	

Personnel records, Annual continuing education/training

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	▪ *State Medicaid Agency*	⌙ *Weekly*	▪ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval =95%*
	⌙ *Other Specify:*	▪ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*	
			⌙ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
▪ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other Specify:*	▪ *Annually*
	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

Performance Measure:	*Number and percent of enrolled providers for which an appropriate background and registry checks were conducted prior to enrollment or as specified in the waiver for on-going verification of provider qualifications* *Numerator: Number of enrolled providers for which an appropriate background and registry checks were conducted timely* *Denominator(n): Total number of enrolled providers due for a background and registry check as specified in the provider qualifications*

Data Source *(Select one) (Several options are listed in the on-line application):*
Record reviews, off-site

If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⌙ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⊏ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⊏ *Representative Sample; Confidence Interval =95%*
	⌙ *Other Specify:*	⊏ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*	
			⌙ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⊏ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other Specify:*	⊏ *Annually*

	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

b Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	*Number and percent of non-licensed providers that continue to meet HCBS enrollment requirements.* *Numerator: Number and percent of non-licensed providers that continue to meet waiver enrollment requirements.* *Denominator(n): Total number of non-licensed providers .*
Data Source *(Select one) (Several options are listed in the on-line application):* ***Record reviews, off-site***	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⌙ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⊏ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⊏ *Representative Sample; Confidence*

				Interval =95%
	⌙ *Other Specify:*	⌐ *Annually*		
		⌙ *Continuously and Ongoing*		⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*		
				⌙ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⌐ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other Specify:*	⌐ *Annually*
	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

c Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	*Proportion of providers that meet training requirements in the waiver* *Numerator: Number and percent of providers that meet waiver training requirements.* *Denominator(n): Total number of providers who are reviewed*
Data Source *(Select one) (Several options are listed in the on-line application):* ***Record reviews, off-site***	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⌙ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⊏ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⊏ *Representative Sample; Confidence Interval =95%*
	⌙ *Other Specify:*	⊏ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*	
			⌙ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⊏ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other Specify:*	⊏ *Annually*
	⌙ *Continuously and Ongoing*
	⌙ *Other*

	Specify:

Add another Performance measure (button to prompt another performance measure)

ii *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

SCDHHS staff sample a representative sample of providers, provider enrollment applications, provider agreements, and provider personnel records (95% Confidence Interval) of provider agencies. SCDHHS staff collect, generate, aggregate, and analyze annually.

b. Methods for Remediation/Fixing Individual Problems

i *Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.*

When issues/problems/concerns are discovered by SCDHHS through formal quality review processes the responsible party is notified by SCDHHS staff in writing. SCDHHS staff identify the problem, make the responsible party aware of the problem, and ensure that they have appropriate information to correct the problem. If SCDHHS deems the problem/issue/concern to cause imminent danger to the waiver operations or children/youths, SCDHHS notifies the responsible party and they are restricted from conducting waiver related supports and services until the issue is resolved and SCDHHS accepts the corrective action plan (CAP). Once written notification is received, the CAP must be submitted within 30 days to SCDHHS. The CAP addresses both immediate problems and identifies how the problems will be avoided in the future. SCDHHS reviews corrective action plans to ensure that they address the underlying issues/concerns. Failure to submit and implement a corrective action plan may result in being excluded from Medicaid.

ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*
	⌙ *Operating Agency*	⌙ *Monthly*
	⌙ *Sub-State Entity*	⌙ *Quarterly*
	⌙ *Other: Specify:*	⊏ *Annually*
		⌙ *Continuously and Ongoing*

		☐ *Other: Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

☐	**No**
☒	**Yes** Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies).*

☐	**Not applicable – The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.**
☐	**Applicable – The State imposes additional limits on the amount of waiver services.**

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; and, (f) how participant are notified of the amount of the limit.

☐	**Limit(s) on Set(s) of Services**. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above*.
☐	**Prospective Individual Budget Amount**. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above*.
☐	**Budget Limits by Level of Support**. Based on an assessment process and/or other factors, participant are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above*.
☐	**Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*

Appendix C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

As a new program, the PCSC 1915(c) waiver requires all provider settings and enrollee residences to comply with the HCBS final rule prior to implementation.

All 1915(c) HCBSs are provided to children/youths who reside in home and community based settings meeting HCBS characteristics (i.e., are not located within or on the grounds of an institutional setting, are integrated in and support full access of children/youths receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree as children/youths not receiving Medicaid HCBS). These children/youths must also receive their 1915(c) HCBSs in their home or in the community.

The CFT/TCM reviews the residence of all children/youths receiving HCBS waiver services and ensure that all child/youth's live services in settings that meet the standards at 42 CFR 441. 301(c)(4) annually through regular health and welfare monitoring. The CFT/TCMs that oversee the child/youth residences work with SCDHHS to report HCB settings violations. SCDHHS reviews and validates compliance for HCBS providers with the setting requirements. SCDHHS enforces compliance actions as necessary.

The CFT/TCM's responsibility is to ensure the child/youth's involvement in decisions that affect his/her care, daily schedules and lifestyles. The overall atmosphere of the setting is conducive to the achievement of optimal independence, safety and development by the child/youth with his/her input. The location of the residence and/or provider is made to provide children/youth reasonable access to the community at large including but not limited to agency, medical, recreational, and shopping areas, by public or agency-arranged transportation. The 1915(c) service is designed to be delivered in community settings including, but not exclusively in the child/youth's home.

Many persons eligible for the 1915(c) services live in their own home or with families or friends in the same manner as any child/youth who does not have a mental illness. Due to the eligibility criteria for the 1915(c) services, there are some children/youths seeking these services who do not have family or friends with whom they can live or are transition age youth not functioning at a level where their health and safety can be supported in a totally independent setting. Depending upon the child/youth's level of need and functioning, the child/youth or his or her guardian may choose to have the child/youth live in full time supervised settings, settings that provide less than full time supervision or settings that provide no on-site supervision. The responses below relate only to living environments that are not fully independent. *Please note: there may be certified residential settings intended to be homes where the child/youth lives. The majority of services and behavioral healthcare is provided in other locations outside of the residence, such as in the community at large or in a clinic setting.*

Home and community-based settings must have all of the following qualities based on the needs of the child/youth as indicated in their person-centered plan:

- The setting is integrated in and supports full access of children/youths receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as children/youths not receiving Medicaid HCBS.
- The setting is selected by the child/youth or his/her guardian from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered plan and are based on the child/youth's or guardian's needs, preferences, and, for residential settings, resources available for room and board.
- The setting ensures a child/youth's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- The setting optimizes, but does not regiment, age-appropriate child/youth initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- The setting facilitates child/youth and guardian choice regarding services and supports, and who provides them.
- In a provider-owned or controlled residential setting, the following additional conditions must be met:
    - The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the guardian of the child/youth receiving services, and the guardian of the child/youth has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement is in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
    - Each child/youth has age-appropriate privacy in their sleeping or living unit:
        - Units have entrance doors lockable by the child/youth, with only appropriate staff having keys to doors.
        - Children/youths sharing units have a choice of roommates in that setting.
        - Children/youths have age-appropriate freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
    - Individuals have age-appropriate freedom and support to control their own schedules and activities, and have access to food at any time.
    - Individuals are able to have visitors of their choosing at any age-appropriate time.
    - The setting is physically accessible to the child/youth.
    - Any modification of the additional conditions, must be supported by a specific assessed need and justified in the person-centered plan. The following requirements must be documented in the person-centered plan:
        - Identify a specific and individualized assessed need.
        - Document the positive interventions and supports used prior to any modifications to the person-centered plan.
        - Document less intrusive methods of meeting the need that have been tried but did not work.
        - Include a clear description of the condition that is directly proportionate to the specific assessed need.

        - Include regular collection and review of data to measure the ongoing effectiveness of the modification.
        - Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
        - Include the informed consent of the guardian of the child/youth.
        - Include an assurance that interventions and supports will cause no harm to the child/youth.
- Home and community-based settings do not include the following:
    - A nursing facility;
    - An institution for mental diseases;
    - An intermediate care facility for children/youths with intellectual disabilities;
    - A hospital; or
    - Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating children/youths receiving Medicaid HCBS from the broader community of children/youths not receiving Medicaid HCBS is presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.

Individuals do not reside or receive 1915(c) HCBS services in any of the following settings:

- Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,
- Any setting that is located in a building on the grounds of, or immediately adjacent to, a public institution, or
- Any other setting that has the effect of isolating children/youths receiving Medicaid HCBS from the broader community of children/youths not receiving Medicaid HCBS

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Person-centered care plan

a. **Responsibility for Service Plan Development**. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(check each that applies)*:

☐	**Registered nurse, licensed to practice in the State**
☐	**Licensed practical or vocational nurse, acting within the scope of practice under State law**
☐	**Licensed physician (M.D. or D.O)**
☐	**Case Manager** (qualifications specified in Appendix C-1/C-3)
☐	**Wraparound facilitator/TCM** (qualifications not specified in Appendix C-1/C-3). *Specify qualifications*:
☐	**Social Worker** *Specify qualifications:*
☒	**Other** *Specify the individuals and their qualifications:*
	Wraparound facilitator/TCM (see definition in Appendix C-1/C-3) leading the CFT/TCM or Targeted Case Manager as outlined under the approved SC State Plan The CFT/TCM is a multi-disciplinary team trained in High Fidelity Wraparound including: a wraparound facilitator/TCM and by credentialed individuals meeting the requirements of a Licensed Practitioner of the Healing Arts or employed by a public entity (LPHA includes a psychiatrist, psychologist, LMSW, LPC, LISW-CP, LISW-AP, or LMFT). In addition, the CFT/TCM will include a peer navigator through the State's contract with a supports broker who supports the families and youth in self-direction. • The peer navigator with lived experience will assist the family with information and assistance in support of participant direction and navigating through the system including completion of any person-centered self-inventories, choice forms, and other required beneficiary input. The peer navigator may assist a participant during the development of a person-centered plan to ensure that the participant's needs and preferences are clearly understood even though the Wraparound facilitator/TCM is responsible for the development of the service plan. The family/child has an upfront choice of receiving peer navigation services and selecting a peer navigator from among the available resources. The family/child is permitted to change peer navigators after the initial assessment is completed or any other point in the process. The family/child is informed about available

	peer navigator resources at the same time upon referral to the PCSC program. • **Wraparound facilitator/TCMs** - Professional experience in human services or social services, a bachelor's degree in a human service or social sciences related field and one year of experience with children with serious emotional or behavioral health challenges • **Wraparound Team Leads –** Professional experience in human services or social services programs, a bachelor's degree in a human service or social sciences related field and three years of experience with children with serious emotional or behavioral health challenges. Must also have experience in provision of high fidelity Wraparound and maintain agency standards as a regional mentor. • **Wraparound Supervisor/Coach** - Professional experience in human services or social services programs, a master's degree in a human services or social sciences related field with two years of case management experience and experience with children with complex emotional or behavioral health challenges, and a minimum of one year of supervisory experience. Must be licensed or have recently applied for licensure as a LMSW, LPC, LISW-CP, LISW-AP, or LMFT.

b. Service Plan Development Safeguards.

Select one:

☐	**Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
☒	**Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.** The State has established the following safeguards to ensure that person-centered plan development is conducted in the best interests of the child/youth. *Specify*:

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Ideally all children/youth under the waiver will be served by a Wraparound facilitator/TCM providing High Fidelity Wraparound (HFW). However, there may be some families who would prefer not to receive HFW or where the child meets targeting criteria and institutional Level of care and is not a candidate for HFW. In those cases, the child/youth will be served by TCM under the regular State Plan. Where the child/youth is a candidate for HFW, the participant will be encouraged but not required to receive case management through the HFW team because of the track record of HFW teams in preventing institutionalization and the overall cost-effectiveness of the totality of the child/youth's care relative to lighter touch case management with this population.

Under HFW, a CFT/TCM including a peer navigator who educates the family about the person-centered plan development process during initial enrollment. Once the family is enrolled in the waiver, SCDHHS assists the family in choosing a wraparound facilitator/TCM/TCM and peer navigator. *All references to Wraparound facilitator/TCM and CFT/TCM here and in the remainder of the waiver include both Wraparound facilitator/TCMs and Targeted Case Managers.* Once a wraparound facilitator/TCM is chosen, the wraparound facilitator/TCM assists the family with choosing other service providers. The CFT/TCM meetings are family driven, child/youth guided and strengths based. The CFT/TCM determines goals and needed services for the waiver child/youth based on recommendations that were made through the level of care assessment and based on the needs of the child/youth and their family. The

purpose of the person-centered plan development process is to ensure that services are identified and goals are being delivered in a person centered way that allows the family to be directly involved in what services/how services are delivered to youth in the waiver. At the family's choice, service providers participate in person-centered plan development meeting every 90 days to ensure coordinated quality of care. CFT/TCM meetings are organized by the wraparound facilitator/TCM who has the responsibility of coordinating with the family to schedule and invite all children/youths selected by the family to the CFT/TCM meetings. Under extenuating circumstances, team members may utilize the use of video conferencing or phone conference methods to participate in the meetings. In the event that a provider cannot attend the meeting, there must be evidence of a conversation regarding person-centered plan development between the youth/family and the wraparound facilitator/TCM documenting that the child/youth and their designees participated in the development of the person-centered plan. The family and any providers listed on the person-centered plan must sign the person-centered plan, signifying agreement with its contents as a condition for authorization by SCDHHS.

The youth and their family have the opportunity during the planning process to decide how their services are delivered, who attends their planning meetings and who provides services to them.

d. Service Plan Development Process In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The CFT/TCM (qualifications specified in Appendix C-1/C-3) or TCM is responsible for the development of the person-centered plan. The team consists of the youth, the family, the wraparound facilitator/TCM and a credentialed individual meeting the requirements of a Licensed Practitioner of the Healing Arts or employed by a public entity, and anyone else that the youth-family wants to participate. A peer navigator to support child-centered family-driven provides supports for self-direction. The CFT/TCM is responsible for reviewing the current person-centered plan, summarizing progress made and suggesting goals and direction for services going forward in a child-centered family-driven manner. The wraparound facilitator/TCM is responsible for planning and coordinating the quarterly CFT/TCM meetings. The wraparound facilitator/TCM is responsible for writing the person-centered plan based on the high fidelity wraparound process and feedback and discussion at any CFT/TCM meetings. The wraparound facilitator/TCM is responsible for the completion of other required paperwork following the quarterly meetings.

Referrals are processed by SCDHHS who assist the youth/family in obtaining an eligibility screen. If a slot is not available, SCDHHS notifies the family and put the child's name on a waiting list; the family is contacted when a slot is available. The availability of slots is on a first come first serve basis. Once a slot is open, SCDHHS assists the youth/family in selecting a CFT/TCM. For children who are in need of immediate services or who are be eligible under the 42 CFR 435.217, a provisional plan of care (crisis plan) may be developed for the initial 60 days until a final person-centered plan is developed. HCBS eligibility begins on the earliest date that all three of the following are in place: the child is found to meet the targeting, risk factors and level of care; the child has a provisional plan of care (crisis plan) or final

person-centered plan; and a financial eligibility determination is effective. The provisional plan of care (crisis plan) may be in effect for no more than 60 days. Children/youths who have agreed to community-based services under the waiver and meet all level of care and financial eligibility requirements are placed in a waiver slot, when there is one available. SCDHHS informs the family of their eligibility status for the waiver.

Once the CFT/TCM is selected, the licensed practitioner of the healing arts or the state public agency employee credentialed to complete the assessment on the team is responsible for completing the CASII assessment, gathering all documentation necessary to substantiate level of care, and scoring the CASII. All information gathered is utilized to determine the CASII score. This CASII score determines level of care eligibility. The CFT/TCM also conducts the CAFAS to assist with service planning. SCDHHS will use the Child and Adolescent Functional Assessment Scale (CAFAS) for the development of the person-centered plan. The CAFAS is completed after eligibility is determined through the CASII and the child is referred for services. The CAFAS is additionally completed upon disenrollment and any time during enrollment when a significant change in identified risk factors or family strengths is observed or a decision regarding changes in level of care is required. The person-centered plan will address all needs addressed in both the CASII and CAFAS. SCDHHS believes that the CAFAS is a more complete tool for service planning while the CASII is a better eligibility tool. The clinician sends the assessments and recommendation on level of care eligibility to SCDHHS indicating hospital placement, waiver services or other recommendations. SCDHHS reviews the recommended level of care and makes the final level of care decision

Once eligibility is determined or the CFT/TCM is certain that the child/youth is eligible, the team begins the person-centered planning process to develop a person-centered plan addressing the goals and needs of the child/youth.

The eligibility decision must be made within three days from the date documentation was received. SCDHHS staff making the determination must be a professional meeting at least the wraparound facilitator/TCM requirements and must successfully complete all the CAFAS training.

The family is required to fill out all necessary paperwork and any financial eligibility forms at this time. They are also asked to sign a Verification of HCBS Child/youth Choice form, indicating that they are choosing community-based services. If a child/youth is found functionally eligible for the waiver, all financial documentation is sent to the eligibility worker, for financial eligibility approval.

Once the youth is found functionally eligible for the waiver, the wraparound facilitator/TCM meets with the family, provides information about the waiver and answers any questions the family may have about the waiver process. The wraparound facilitator/TCM discusses and determines needed services with the family, based on the needs of the family and the recommendations from the CASII and CAFAS assessment, and assists the family to choose from a list of qualified providers to determine who will provide those services. The family chooses who they would like to participate in the person-centered plan development process and chooses the time/location of the meeting. The wraparound facilitator/TCM works with the youth and family to convene a CFT/TCM meeting. The CFT/TCM discusses the waiver and the criteria for eligibility with the family. Applicants for the waiver are required to provide wraparound facilitator/TCM with documentation of the child's needs (and to substantiate the findings of the eligibility screen) and the need for waiver services prior to moving forward with the eligibility process.

Prior to the first CFT/TCM meeting, the level of care assessment and recommendations from the eligibility screen serve as the provisional person-centered plan (crisis plan). The family may begin receiving services developed in the provisional person-centered plan (crisis plan) after all eligibility requirements have been met and they are enrolled in the waiver if there were immediate service needs

identified on the provisional person-centered plan (crisis plan). The provisional person-centered plan (crisis plan) is valid no more than 60 days from the date the child was admitted to the waiver. The first meeting to develop the initial person-centered plan must be held within 30 days from the date the child was admitted to the waiver.

At the first CFT/TCM meeting, the family, with the assistance of the other children/youths, determines what services are needed to maintain the child in the home. Information gathered from the initial assessment and the CASII/CAFAS is used to support this process. The family then selects providers from a list of qualified providers. The person-centered plan includes a crisis plan that clearly signifies the protocol and responsibility for handling crises, including after-hour calls. The team must develop a budget that reflects the amount that to be spent to provide the services listed. A budget template form is provided to assist with this process. The person-centered plan must contain all items required in the HCBS regulations. When the person-centered plan and budget have been developed and signed by the wraparound facilitator/TCM, the family, and the providers, the wraparound facilitator/TCM submit them to SCDHHS for final approval. Once approved, the wraparound facilitator/TCM coordinates with the family and service providers to begin services.

The CFT/TCM is required to meet at least every 90 days; beginning from the date the initial person-centered plan was approved. This timeframe is the minimum requirement. It may be determined at the first CFT/TCM meeting that the team needs to meet more frequently. The family can request a meeting at any time.

Providers of services, at the child/youth and guardian's option, should participate in CFT/TCM meeting and give updates on progress. Under extenuating circumstances, a provider may utilize the use of video conferencing or phone conference methods to participate in the meetings. The family and team members use this time to review the person-centered plan and discuss any issues or concerns they may have. The person-centered plan is reviewed and changed, as needed. The plan and budget must include all the required elements prior to the budget being authorized by SCDHHS.

The person-centered plan is the map for the family to ensure that there are sufficient supports and services for the child to be supported in his/her home. The person-centered plan includes appropriate identifying information: the child/youth's name, Medicaid number, date of birth and date of the plan. The person-centered plan identifies strengths and support needs for the waiver children/youths. Someone reading the person-centered plan should be able to get an idea about why this child/youth is receiving waiver services. The plan identifies the provider of the service, type of service, frequency and duration of the service. The person-centered plan identifies goals for each service type that the youth, their family and the person-centered plan development team have identified through the person-centered plan development process. Goals are stated from the perspective of the child to reinforce the person-centered emphasis on waiver supports and services. Where appropriate, the person-centered plan details how the staff/clinician/provider supports the waiver child/youth to reach their goal. Identifying goals and staff actions provides direction to the providers and ensures that providers have an understanding of what the supports and services should look like based on the clinical recommendations and needs/wants of the family. Identifying goals and staff actions on the person-centered plan ensures that providers are accountable for actively addressing the goals that the child and family would like to reach with the support of waiver services.

The person-centered plan includes all of the following:

- The person-centered plan must reflect the services and supports that are important for the child/youth to meet the needs identified through an assessment of functional need, as well as what is important to the child/youth with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the child/youth, and the scope of services and

supports available under the State's 1915(c) Home- and Community-Based Settings (HCBS) waiver, the written plan must:

- Reflect that the setting in which the child/youth resides is chosen by the child/youth. The State must ensure that the setting chosen by the child/youth is integrated in, and supports full access of, children/youths receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as children/youths not receiving Medicaid HCBS.
- Reflect the child/youth's strengths and preferences.
- Reflect clinical and support needs as identified through an assessment of functional need.
- Include individually identified goals and desired outcomes.
- Reflect the services and supports (paid and unpaid) that assists the child/youth to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the child/youth in lieu of 1915(c) HCBS waiver services and supports.
- Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.
- Be understandable to the child/youth receiving services and supports, and the children/youths important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to children/youths with disabilities and persons who are limited English proficient, consistent with §435.905(b) of this chapter.
- Identify the child/youth and/or entity responsible for monitoring the plan.
- Be finalized and agreed to, with the informed consent of the child/youth in writing, and signed by all children/youths and providers responsible for its implementation.
- Be distributed to the child/youth and other people involved in the plan.
- Include those services, the purpose or control of which the child/youth elects to self-direct.
- Prevent the provision of unnecessary or inappropriate services and supports.
- Document that any modification of the additional conditions, under paragraph (c)(4)(vi)(A) through (D) of this section, must be supported by a specific assessed need and justified in the person-centered plan. The following requirements must be documented in the person-centered plan:
    - Identify a specific and individualized assessed need.
    - Document the positive interventions and supports used prior to any modifications to the person-centered plan.
    - Document less intrusive methods of meeting the need that have been tried but did not work.
    - Include a clear description of the condition that is directly proportionate to the specific assessed need.
    - Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
    - Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
    - Include informed consent of the child/youth.
    - Include an assurance that interventions and supports will cause no harm to the

child/youth.

- Review of the person-centered plan. The person-centered plan must be reviewed, at least every 3 months, and revised upon reassessment of functional need when the child/youth's circumstances or needs change significantly, or at the request of the child/youth.

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Potential risks to the child/youth are identified through the CAFAS, the initial assessment and annual re-assessments. Specific issues are addressed during the CFT/TCM meetings. The person-centered plan includes a crisis plan to help mitigate these identified risks. The CFT/TCM develops the crisis plan taking into account natural and professional supports that are available to the family. The protocol to address crises as well as the providers required to respond is clearly be noted in the crisis plan. The person-centered plan is not be approved by SCDHHS if these components are not included.

f. Informed Choice of Providers. Describe how participant are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Families are fully informed about how the person-centered plan development process works by the wraparound facilitator/TCM and by the CFT/TCM including the peer navigator. The family is informed and asked to sign off on a freedom of choice form to ensure and document that each child/youth is aware of their right to choose providers. Families are informed that they have the option of changing service providers, including their wraparound facilitator/TCM, at any time. A wraparound facilitator/TCM provides this information during enrollment.

In addition, the CFT/TCM serves as an advisory board for the youth and family to support them in making informed decisions about the services they receive and the providers they choose. The CFT/TCM is made up of the youth, family, wraparound facilitator/TCM, and, at the child/youth's option, all the service providers as well as anyone else that the youth/family would like to participate.

Children/youths and their families are given contact information for the CFT/TCM as well as contact information for staff at SCDHHS. Families are encouraged to bring their concerns to the local level and move up to the chain of command, if needed. If they feel they are not getting appropriate action, they can contact SCDHHS at any time.

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The wraparound facilitator/TCM is responsible for writing up the person-centered plan that has been agreed upon by the CFT/TCM. The person-centered plan is signed, dated and titled by the wraparound facilitator/TCM and all providers. The family must also sign the person-centered plan as verification that they are in agreement with its contents. The person-centered plan, along with the proposed budget and crisis plan, are submitted to SCDHHS for approval. If SCDHHS needs more information or clarification about the plan, the wraparound facilitator/TCM is notified.

Once the person-centered plan is authorized by SCDHHS, the wraparound facilitator/TCM must send a full copy of the person-centered plan to each of the service providers as well as a copy for the

family/youth.

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

☐	**Every three months or more frequently when necessary**
☐	**Every six months or more frequently when necessary**
☐	**Every twelve months or more frequently when necessary**
☐	**Other schedule** *Specify the other schedule*:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies)*:

☐	**Medicaid agency**
☐	**Operating agency**
☐	**Care Manager**
☐	**Other** *Specify:*

Appendix D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

A) The CFT/TCM and SCDHHS are the entities that are responsible for monitoring the implementation of the person-centered plan, and ensuring child/youth health and welfare.

B) After the person-centered plan is approved by SCDHHS, the CFT/TCM, with the wraparound facilitator/TCM taking the lead, assists with coordinating and setting up the appointments for the services listed in the person-centered plan. Wraparound facilitator/TCMs are required to contact the family twice a month to monitor and oversee that the family is able to access all services listed on the person-centered plan. Both waiver and non-waiver services listed on the person-centered plan are monitored by the CFT/TCM. At least one of these monthly contacts must be face-to-face with the family. All contacts must be documented; all documentation must include the child/youth's name, Medicaid number, date of service, duration of service, location or mode of contact and must identify case management activities that were provided during the time frame. The service documentation must be signed, titled and dated by the CFT/TCM member who rendered the service. Services that are not billable should also be documented the same way to show progress in treatment.

The CFT/TCM is required to meet at least every 90 days to review the person-centered plan and discuss progress or any changes that may be needed. In addition, if issues arise concerning implementation and/or child/youth health or welfare, the family can call a CFT/TCM meeting at any time. In addition, families can contact their wraparound facilitator/TCM, the CFT/TCM or SCDHHS directly at any time to discuss any issues that may arise.

Follow-up and remediation of identified problems should occur at the local level first and then move up the chain of command, if needed. The wraparound facilitator/TCM is required to promptly address any concerns the family may have on the implementation of the person-centered plan and/or any child/youth health and welfare issues. If the concerns cannot be addressed at this level, the wraparound facilitator/TCM notifies the peer navigator on the CFT/TCM who intervenes. The youth/family may also contact another member of the CFT/TCM to intervene if they do not feel comfortable having the wraparound facilitator/TCM do this for them. If the peer navigator on the CFT/TCM is not able to resolve the issues, SCDHHS is notified. The family may utilize the grievance process to have their concern addressed.

SCDHHS reviews the person-centered plan to authorize waiver services and for quality purposes for each child/youth. SCDHHS also conducts an annual quality review to verify that services were provided in accordance of the person-centered plan. Concerns discovered during those reviews are further investigated by SCDHHS.

b. Monitoring Safeguards. *Select one:*

☐	**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
☐	**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.** The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:
	Wraparound facilitator/TCMs have a responsibility to monitor person-centered plan implementation and child/youth health and welfare. By design the wraparound facilitator/TCM's role is to monitor services to ensure they are being delivered according to the person-centered plan. Wraparound facilitator/TCMs are not be permitted to provide direct services to any waiver children/youths. SCDHHS staff review all person-centered plans and authorize all waiver services prior to services being delivered. This review ensures that services are being identified in the person-centered plan. SCDHHS also performs annual quality reviews for each provider of waiver services to ensure that there is no conflict of interest as defined under the HCBS regulation for the members of the CFT/TCM. Families have the ability to choose from a list of qualified waiver providers. Families can change providers at any time while enrolled in waiver services. If the family is not satisfied with a service or a provider, the family is offered support from the family advocacy organization which addresses the issue through a mediation process. Grievance procedures are utilized as needed.

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Service Plan Assurance**

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participant.

i. Sub-assurances:

a. Sub-assurance: Service plans address all participant' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	*Number and percent of children/youths whose person-centered plans address their assessed needs, including health and safety risk factors, and personal goals.* *Numerator: Number of children/youths whose person-centered plans address their assessed needs, including health and safety risk factors, and personal goals* *Denominator: Total number of children/youths reviewed*
Data Source *(Select one) (Several options are listed in the on-line application):* ***Record reviews, on-site***	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⊏ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval =*
	⌙ *Other Specify:*	⊏ *Annually*	

		⌙ *Continuously and Ongoing*		⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*		
				⌙ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⌙ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other Specify:*	⌙ *Annually*
	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

b.Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	*Proportion of children/youths whose plans were completed/revised prior to the provision of waiver services.* *Numerator: Total number of children/youths with plans that were completed/revised prior to the provision of waiver services*

	Denominator: Total number of children/youths reviewed.

Data Source *(Select one) (Several options are listed in the on-line application):*
Record reviews, on-site

If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⊏ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval =*
	⌙ *Other Specify:*	⊏ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*	
			⌙ *Other Specify:*

Performance Measure:	*The proportion of service plans developed that followed the process outlined in the waiver.* *Numerator: Total number of service plans that followed the process outlined in the waiver* *Denominator: Total number of service plans.*

Data Source *(Select one) (Several options are listed in the on-line application):*
Record reviews, on-site

If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⊏ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100%*

			Review
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval =*
	⌙ *Other Specify:*	⌐ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*	
			⌙ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⌐ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other Specify:*	⌐ *Annually*
	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed

statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	*Proportion of person-centered plans updated/revised at least annually or when warranted by changes in the waiver participant's needs* *Numerator: Number of person-centered plans reviewed that were updated/revised at least annually or more frequently than annually when needs changed* *Denominator(n): Total number of children/youths reviewed*
Data Source *(Select one) (Several options are listed in the on-line application):* ***Other***	
If 'Other' is selected, specify:	
SCDHHS IT system	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⊏ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval =*
	⌙ *Other Specify:*	⊏ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*	
			⌙ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⊏ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other*	⊏ *Annually*

Specify:	
	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

d. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	*Proportion of children/youths reviewed who received services in the type, scope, amount, duration and frequency specified in the person-centered plan.* *Numerator: Number of children/youths reviewed who received services in the type, scope, amount, duration and frequency specified in the person-centered plan* *Denominator: Total number of children/youths reviewed*
Data Source *(Select one) (Several options are listed in the on-line application):* ***Record review on-site***	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⊏ *100% Review*

	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval =*
	⌙ *Other Specify:*	⌐ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*	
			⌙ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⌐ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other Specify:*	⌐ *Annually*
	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

e. Sub-assurance: Participants are afforded choice between/among waiver services and providers.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed

statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	*Proportion of participants notified of their rights to choose among waiver services and/or providers.* *Numerator: Number of participants notified of their rights to choose among waiver services and/or providers* *Denominator: Total number of participants reviewed*
Data Source *(Select one) (Several options are listed in the on-line application):* ***Record reviews, off-site***	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⊏ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval =*
	⌙ *Other Specify:*	⊏ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*	
			⌙ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⊏ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other*	⊏ *Annually*

Specify:	
	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.*

When issues/problems/concerns are discovered by SCDHHS through formal quality review processes, the responsible party is notified by SCDHHS staff. SCDHHS staff identifies the problem, makes the responsible party aware of the problem and ensures that they have appropriate information to correct the problem. SCDHHS staff formally issues a statement of deficiency requiring a corrective action plan (CAP). If SCDHHS deems the problem/issue/concern to cause imminent danger to the waiver operations or children/youths, SCDHHS notifies the responsible party and the responsible party is restricted from conducting waiver related supports and services until the issues are resolved and SCDHHS accepts the CAP. Once written notification is received, the CAP must be submitted within 30 days to SCDHHS. The corrective action plan addresses both immediate problems and identifies how the problems will be avoided in the future. SCDHHS reviews corrective action plans to ensure that they address the underlying issues/concerns. Failure to submit and implement a corrective action plan may result in being excluded from Medicaid.

When issues/problems/concerns are discovered by SCDHHS through informal processes, the responsible party is contacted by SCDHHS staff. SCDHHS staff identifies the problem, makes the responsible party aware of the problem and ensures that they have appropriate information to correct the problem. If SCDHHS deems the problem/issue/concern to cause imminent danger to the waiver operations or children/youths, SCDHHS ensures that immediate action is taken to protect the health and welfare of the child/youth, issues a formal notice of deficiency, and notifies the responsible party. If the issue/problem/concern is of a less serious nature, SCDHHS staff documents the contact and the request for correction to ensure that there is timely and appropriate follow up. The responsible party is given an opportunity to correct the problem informally and submit corrections to SCDHHS staff. If the problem is not addressed in a timely way, SCDHHS staff formally issues a statement of deficiency requiring a corrective action plan. Once written notification is received, the CAP must be submitted within 30 days to SCDHHS. The corrective action plan addresses both immediate problems and

identifies how the problems will be avoided in the future. SCDHHS reviews corrective action plans to ensure that they address the underlying issues/concerns. Failure to submit and implement a corrective action plan may result in being excluded from Medicaid.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	**Responsible Party** *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **State Medicaid Agency**	☐ **Weekly**
	☐ **Operating Agency**	☐ **Monthly**
	☐ **Sub-State Entity**	☐ **Quarterly**
	☐ **Other** Specify:	☐ **Annually**
		☐ **Continuously and Ongoing**
		☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

☐	**No**
☐	**Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request):*

☐	**Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
☒	**No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participant the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

☒	**Yes. The State requests that this waiver be considered for Independence Plus designation.**
☐	**No. Independence Plus designation is not requested.**

Appendix E-1: Overview

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participant; (b) how participant may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

This waiver offers child/youth's and their representatives to self-direct only the Individualized Goods and Services (IGS) under the Employer and Budget Authorities. The child/youth or his/her guardian can choose to direct the child/youth's care for this one service. This allows them to contract with the entity of their choice to address the identified need in the child's person-centered plan that is not otherwise provided or supplied under this waiver or through the Medicaid State Plan.

Children/youths/guardians must have no communication or cognitive deficit that would interfere with their ability to self-direct IGS.

Peer Support Broker will provide detailed information to the child/youth or guardians about IGS and child/youth/guardians direction as an option including the benefits and responsibilities of the option. If the child/youth/guardian wants to pursue this service, additional information about the risks, responsibilities and liabilities of the option is shared by the wraparound facilitator/TCM. Once the child/youth has chosen to direct their individual goods and service, wraparound facilitator/TCMs continue to monitor service delivery and the status of the child/youth's health and safety.

Information about the IGS (which involves no workers) and the role of the Financial Management System (FMS) is also provided. Self-directed children/youths access financial management services through the FMS. The FMS is an administrative contractor authorized by SCDHHS to provide FMS reimbursement for IGS services. Under this model, the FMS provides purchasing supports to the self-direction child/youth. Because there is no literal employer role other than ensuring that the provider of IGS meets qualifications and that the services purchased are valid services under the person-centered plan, the FMS's role is to ensure that the provider of IGS is reimbursed for the provision of IGS

services. Under this option, the child/youth and his or her family can exercise budget authority with the assistance of the FMS. In this option, the FMS provides IRS form support and reimburses for services rendered.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

ㅗH	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
ㅗH	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participant who have authority over a budget.
ㄱ	**Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

ㅇ	**Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
ㄹ	**Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
ㄹ	**The participant direction opportunities are available to persons in the following other living arrangements** *Specify* these living arrangements:

d. Election of Participant Direction. Election of participant direction is subject to the following policy (s*elect one):*

ㅗH	**Waiver is designed to support only individuals who want to direct their services.**
ㅗH	**The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
ㄱ	**The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.** *Specify the criteria*
	The child/youth or guardian must have no communication or cognitive deficits that would interfere with child/youth or guardian direction with IGS. The wraparound facilitator/TCM assesses and determine if these criteria are met. Children/youths interested in self-directed care are prescreened to assure capability utilizing a standardized pre-screen form used in other SC waivers. The prescreening form utilized is standardized across waiver programs and assesses three main areas of ability that are critical to self-direction and assuring the health and welfare

	of the child/youth. These include: communication, cognition patterns, and mood and behavior patterns. The communication section assesses the ability of the child/youth/guardian to make themselves understood and the ability of others to understand the child/youth/guardian. The cognitive patterns section evaluates both the short-term memory and cognitive skills for daily decision making of the child/youth/guardian. Finally, the assessment tool reviews the mood and behavior patterns of the child/youth/guardian to assess sad/anxious moods. The assessment is scored based on these three areas and the results are shared with the child/youth/guardian. If the child/youth/guardian disagrees with the results they may appeal the decision. SCDHHS assesses the cognitive and communication abilities of children/youths/family members who wish to direct some of their waiver services. This process is consistent for all children/youths meeting the level of care for this waiver. Because IGS is the only service being self-directed and it does not require on-going employment related abilities such as supervision of workers, the standardized pre-screen form is not anticipated to be a barrier to most families wishing to self-direct this service.

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

At the time of the initial assessment, if IGS is identified as a beneficial service for the child/youth/family, the wraparound facilitator/TCM introduces child/youth direction of IGS and provide a brochure giving information about this option. If the child/youth/guardian is interested, the wraparound facilitator/TCM provides more details about the benefits and responsibilities of child/youth direction and determines continued interest. The wraparound facilitator/TCM provides information about the benefits as well as the risks, responsibilities and liabilities of child/youth direction. If not initially interested, the wraparound facilitator/TCM continues to assess the child/youth's needs and interest on an annual basis.

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one)*:

☐	**The State does not provide for the direction of waiver services by a representative.**	
☐	**The State provides for the direction of waiver services by representatives.** Specify the representatives who may direct waiver services: *(check each that applies)*:	
	☐	**Waiver services may be directed by a legal representative of the participant.**
	☐	**Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:
		A child/youth may choose to have waiver services directed by a representative and he/she choose anyone (subject to SCDHHS or Medicaid policy) willing to understand and assume the risks, rights and responsibilities or directing the child/youth's care. The chosen representative must demonstrate a strong personal commitment to the child/youth and knowledge of the child/youth's preferences. The representative must be willing to complete the necessary paperwork and serve as the employer of record. The representative must be at least 21 years of age.

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Individual Goods and Services	o	o
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

☐	**Yes**. **Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).* Specify whether governmental and/or private entities furnish these services. *Check each that applies:*
	☐ **Governmental entities**
	o **Private entities**
☒	**No**. **Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. S*elect one*:

☒	FMS are covered as the waiver service specified in Appendix C-1/C-3 **The waiver service entitled:** Financial Management System [insert name]	
☐	**FMS are provided as an administrative activity.** ***Provide the following information***	
i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:	
	SCDHHS currently uses an FMS to provide these services to children/youths in other 1915(c) waivers operated by SCDDSN. SCDHHS would use the same entity under a separate administrative contract. This is a sole source procurement with a government entity.	
ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:	
	The State compensates the FMS entity through administrative funds. The payment to the FMS does not affect the child/youth's waiver budget. The scope of supports provided by the	

FMS includes:

- Processing, filing, and payment of applicable federal, state, and local taxes and insurances; and
- Verification of the IGS provider's minimum qualifications.

SCDHHS monitors the performance of the FMS monthly by monitoring expenditures. Additionally, an independent audit of the FMS is conducted yearly.

iii. **Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*

Supports furnished when the participant is the employer of direct support workers:

- ☑ **Assists participant in verifying support worker citizenship status**
- ☑ **Collects and processes timesheets of support workers**
- ☑ **Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ○ **Other**

  Specify:

  The FMS will verify the IGS provider's minimum qualifications.

Supports furnished when the participant exercises budget authority:

- ○ **Maintains a separate account for each participant's participant-directed budget**
- ○ **Tracks and reports participant funds, disbursements and the balance—of participant funds**
- ○ **Processes and pays invoices for goods and services approved in the service plan**
- ○ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☑ **Other services and supports**

  Specify:

Additional functions/activities:

- ○ **Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ○ **Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ○ **Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- ○ **Other**

  Specify:

  Receive and disburse funds for the payment of child/youth-directed services under an agreement with SCDHHS.

iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how

	frequently performance is assessed.
	An annual independent audit is required to verify that expenditures are accounted for and disbursed according to General Accepted Accounting Practices.

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

○	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*	
	The wraparound facilitator/TCM provides any information regarding self-direction of IGS necessary for the child/youth and ensures that the child/youth is aware of how to work with the FMS to ensure that the provider is qualified and that goods and services are reimbursed properly.	
☒	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-1/C-3 (check each that applies):	
	Participant-Directed Waiver Service	**Information and Assistance Provided through this Waiver Service Coverage**
	(list of services from Appendix C-1/C-3)	☒
☒	**Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and (e) the entity or entities responsible for assessing performance:*	

k. Independent Advocacy *(select one)*.

○	**No. Arrangements have not been made for independent advocacy.**
●	**Yes**. Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service

delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

The wraparound facilitator/TCMs accommodates the child/youth by providing a list of qualified providers from which a provider can be selected in order to maintain service delivery. The wraparound facilitator/TCM and SCDHHS work together to ensure the health and safety of the child/youth in this transition and work to avoid any break in service delivery.

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

If the child/youth or his/her representative is no longer able to communicate or if they experience cognitive deficits which keep them from acting in their best or the child/youth's best interest, the wraparound facilitator/TCM transitions services and cease the provision of IGS. SCDHHS uses written criteria in making this determination. The child/youth and/or representative is informed of the opportunity and means of requesting a fair hearing and the plan is revised to accommodate changes in the child/youth's person-centered plan necessary for the child/youth to remain in their home.

When it is determined that child/youth/family direction of services is no longer appropriate, alternate, provider-directed services are authorized to ensure continuity of care and assure child/youth health and welfare. This waiver targets only those children/youths who elect to self-direct the Individualized goods and services or have an appropriate family member to do so. However, if waiver children/youths/family members become unable/unwilling to direct the Individualized goods and services and it becomes necessary to terminate the service, the person-centered plan is modified to accommodate other HCBS services available to ensure continuity of care.

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	**Budget Authority Only or Budget Authority in Combination with Employer Authority**
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		100
Year 2		125
Year 3		150
Year 4 (only appears if applicable based on Item 1-C**)**		175
Year 5 (only appears if		200

applicable based on Item 1-C)		

Appendix E-2: Opportunities for Participant-Direction

a. Participant – Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

☑	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff:
○	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑	**Recruit staff**
☑	**Refer staff to agency for hiring (co-employer)**
☑	**Select staff from worker registry**
☑	**Hire staff (common law employer)**
☑	**Verify staff qualifications**
☑	**Obtain criminal history and/or background investigation of staff** Specify how the costs of such investigations are compensated:
○	**Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
☑	**Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☑	**Determine staff wages and benefits subject to applicable State limits**
☑	**Schedule staff**
☑	**Orient and instruct staff in duties**
☑	**Supervise staff**
☑	**Evaluate staff performance**
☑	**Verify time worked by staff and approve time sheets**

☑	**Discharge staff (common law employer)**
☑	**Discharge staff from providing services (co-employer)**
○	**Other** Specify:
	Choose the vendor of IGS and ensure that the vendor meets the qualifications in Appendix C.

b. Participant – Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more***:**

☑	**Reallocate funds among services included in the budget**
○	**Determine the amount paid for services within the State's established limits**
☑	**Substitute service providers**
○	**Schedule the provision of services**
○	**Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
○	**Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
○	**Identify service providers and refer for provider enrollment**
○	**Authorize payment for waiver goods and services**
☑	**Review and approve provider invoices for services rendered**
☑	Other Specify:

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

An IGS resource allocation is established for each child/youth. The IGS resource allocation represents a target amount of resources available to the child/youth for the cost of the supports and services they need. The budget for Individualized Goods and Services is limited to $2,000 lifetime per child.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Children/youths and their representatives who choose to direct their services can get information on their IGS resource allocation from their wraparound facilitator/TCM at the beginning of the planning process. Through the person-centered planning process, the person defines their own specific needs and with the assistance of the Individualized goods and services and designs their own person-centered plan and corresponding budget costs. If the budgeted costs are less than the lifetime value, the plan and the budget are given the streamlined approval. If the budgeted costs exceed the lifetime value, review occurs at the state

level to plan for appropriate services within the IGS resource allocation target value.

Children/youths can also request to change any aspect of their self-directed person-centered plan and budget during the implementation phase to achieve evolving personal goals and valued outcomes, and to prevent institutionalization. There are two set opportunities to make changes to the person-centered plan and budget yearly plan or the IGS resource allocation which align with the reviews of their person centered plan. Individuals are afforded an immediate opportunity to request a change to their person centered plan and budget if circumstances occur that imminently threaten the life, safety and/or welfare of the child/youth. Children/youths and their representatives are assisted through these change processes by their wraparound facilitator/TCMs.

iv. Participant Exercise of Budget Flexibility. *Select one:*

☐	**Modifications to the participant directed budget must be preceded by a change in the person-centered plan.**
☒	**The participant has the authority to modify the services included in the participant directed budget without prior approval.** Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
☐	

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

There are a number of safeguards and other resources designed to prevent the premature depletion of the child/youth-directed individualized budget as well as to address potential problems related to service delivery.

The FMS tracks expenditures of IGS and ensures that the child/youth does not exceed the budget. A reminder is sent to the child/youth/guardian and wraparound facilitator/TCM when the funds are 90% expended. The main function of wraparound facilitator/TCM related to IGS is to assist the child/youth to manage their individual budget. Wraparound facilitator/TCMs review annual expenditure reports with the child/youth and their representative to ensure that expenses are appropriate. CFT/TCMs are required to meet at least once every three months (quarterly) but meets as often as the child/youth requires to assist with any issues related to the IGS resource allocation. Other areas of support include:

- continual identification of revised or emerging valued outcomes and the supports needed to address them;
- on-going planning and maintenance of the self-directed budget;
- review of individualized budget expenditure reports to ensure that available resources remain adequate to meet approved services and supports;
- assistance in ensuring that risk, responsibilities, and consequences are understood and adhered to and that safeguards are revised, if needed, to adequately address needs, and;

- helping to ensure that health and safety concerns are immediately identified and addressed.

The wraparound facilitator/TCM is the liaison or authorized designee to the FMS for issues related to the co-management of his or her self-directed budget.

A core function of FMS is to develop and implement an accounting and information system to track and report child/youth-directed support funds. The FMS makes payments based on a current, approved budget which outlines the annual costs the child/youth incurs and how these costs are paid over the course of the year. The FMS must ensure that there are sufficient funds available within the child/youth account to make the necessary payments.

The FMS must develop a mechanism to identify those children/youths who incur expenses in excess of expected spending. Under use of IGS is not considered a health and welfare issue unless identified as such by the CFT/TCM. Either circumstance must immediately be reported to the child/youth (or authorized designee where appropriate). The FMS must also generate detailed support funds and expenditure reports to children/youths, their representatives, their CFT/TCM on a semi-annual basis. These reports must be customized, as appropriate to their intended audience, to ensure that children/youths and members of their CFT/TCM can understand them.

FMS agency submits the expenditure reports to the wraparound facilitator/TCM who addresses issues related to depleting fiscal resources and over/under-utilization of approved services with the child/youth. The child/youth works with his or her CFT/TCM to determine the need to revise the self-directed plan and budget.

An FMS checklist, which highlights the general responsibilities of the FMS, is shared with all children/youths using FMS to self-direct services. On-going training is also provided to all parties on their roles and responsibilities.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Prior to entrance in the waiver, the reconsideration/appeals process is provided and explained to applicants by the family advocate at the time of the Freedom of Choice document is explained.

The formal process of review and adjudication of actions/determinations are done under the authority of S.C. Code Ann. § 1-23-310 et seq., as amended, and the Department of Health and Human Services regulations Section 126-150, et seq.

A request for reconsideration of an adverse decision must be sent in writing to the Division Director of Family Services at SCDHHS, P. O. Box 8206, Columbia, SC 29202-8206. The reconsideration process must be completed in its entirety before seeking an appeal to the SCDHHS Division of Appeals and Hearings.

A written request for reconsideration must be made within thirty (30) calendar days of the date of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the child/youth, representative, or person assisting the child/youth in filing the request. If necessary, the family advocate assists the child/youth in filing a written reconsideration.

In order for waiver benefits/services to continue during the reconsideration/appeal process, the youth/family's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the youth/family may be required to repay waiver benefits received during the reconsideration/appeal process.

The Division Director or his/her designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the youth/family. If the Division Director/designee upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the youth/family/representative fully completes the above reconsideration process and is dissatisfied with the results, the youth/family/representative has the right to request an appeal to the SCDHHS Division of Appeals and Hearings. The purpose of an administrative appeal is to prove error in fact or law. The youth/family/representative must submit an appeal no later than thirty (30) calendar days from the date of the Division Director's written reconsideration decision. Appeals can be filed online at www.scdhhs.gov/appeals; faxed to (803) 255-8206; or mailed to:

Division of Appeals and Hearings
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

There is also an on-line link on the SCDHHS website for filing on-line State Fair Hearings: https://msp.scdhhs.gov/appeals/site-page/file-appeal.

The youth/family/representative must include a copy of the denial notices or initial and reconsideration denials received from the SCDHHS regarding the specific matter on appeal. In the appeal request the youth/family must state with specificity, which issue(s) the youth/family wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the date of the SCDHHS Division Director's written reconsideration decision, the decision is final and binding without special consideration of good cause by the hearing officer. An appeal request is considered filed at the above address if received by the thirtieth (30th) calendar day following the date of the Division Director's written reconsideration decision. The youth/family shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one*:

☐	**No. This Appendix does not apply**
☒	**Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

ㅡH	**No. This Appendix does not apply**
ㄱ	**Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

SCDHHS

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

This waiver operates a grievance/complaint system that affords children/youths the opportunity to file a grievance or complaint concerning the provision of services. Some examples of grievances or complaints that may be registered include: dissatisfaction with a provider, dissatisfaction with the course of treatment or dissatisfaction with the operating/administrative entity.

Children/youths are informed of their right to file a grievance or complaint, during the enrollment process. The family contacts the wraparound facilitator/TCM or SCDHHS representative (in the case of complaints/grievances about wraparound facilitator/TCMs) to report their grievance/complaint. The family must also submit a written statement concerning the grievance. The grievance cannot be formally addressed until a written statement is submitted to report the grievance. Once a written statement is submitted, the grievance is addressed through a local mediation process. The wraparound facilitator/TCM/SCDHHS representative is responsible for setting up the mediation session. If the grievance is resolved, it shall be acknowledged in writing and documented in the child/youth's record at SCDHHS.

If the family is not satisfied with the outcome of the mediation, they may appeal in writing to the SCDHHS waiver director. The wraparound facilitator/TCM/SCDHHS representative can assist the family with this process. SCDHHS waiver staff investigates the grievance and the issues are addressed in the mediation session. SCDHHS must issue a written decision within ten working days from the date the grievance was received in writing. If the grievance is resolved, it shall be acknowledged in writing and documented in the child/youth's record at SCDHHS.

If the family is not satisfied and the grievance is not a reduction or termination of services entitled to a State Fair Hearing, the grievance is completed with the decision of the SCDHHS waiver director.

Only grievances involving a reduction or termination of services or eligibility where the complainant has fair hearing rights may be appealed to the fair hearing process.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one*:

☐	**Yes**. **The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
☒	**No**. **This Appendix does not apply** (*do not complete Items b through e).* *If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.*

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

An assessment must be administered and submitted within seven days to SCDHHS after any incidents of abuse, neglect, and/or exploitation committed by or to waiver children/youths. Waiver staff must be notified of any follow-up information available within 48 hours of discovery and all requested follow-up docs have to be submitted to SCDHHS within 48 hours of the request. The CASII is additionally completed upon disenrollment and any time during enrollment when a significant change in identified risk factors or family strengths is observed or a decision regarding changes in level of care is required

S.C. Code Ann. § 63-7-10 et seq, states that Mandated reporters of abuse, neglect and exploitation must report any allegation of abuse, neglect and exploitation that they become aware of. The reports must be made to those State agencies having statutory authority to receive reports and investigate allegations of suspected abuse, neglect and exploitation. These reports can be made by phone or written form. All verbal reports shall subsequently be submitted in writing.

Definition: "Child abuse or neglect" or "harm" occurs when the parent, guardian, or other person responsible for the child's welfare:

- Inflicts or allows to be inflicted upon the child physical or mental injury or engages in acts or omissions which present a substantial risk of physical or mental injury to the child, including injuries sustained as a result of excessive corporal punishment, but excluding corporal punishment or physical discipline which:
  - is administered by a parent or person in loco parentis;
  - is perpetrated for the sole purpose of restraining or correcting the child;

- is reasonable in manner and moderate in degree;
- has not brought about permanent or lasting damage to the child; and
- is not reckless or grossly negligent behavior by the parents.

- Commits or allows to be committed against the child a sexual offense as defined by the laws of this State or engages in acts or omissions that present a substantial risk that a sexual offense as defined in the laws of this State would be committed against the child;

- Fails to supply the child with adequate food, clothing, shelter, or education as required under Article 1 of Chapter 65 of Title 59, supervision appropriate to the child's age and development, or health care though financially able to do so or offered financial or other reasonable means to do so and the failure to do so has caused or presents a substantial risk of causing physical or mental injury. However, a child's absences from school may not be considered abuse or neglect unless the school has made efforts to bring about the child's attendance, and those efforts were unsuccessful because of the parents' refusal to cooperate. For the purpose of this chapter "adequate health care" includes any medical or nonmedical remedial health care permitted or authorized under State law;

- Abandons the child;

- Encourages, condones, or approves the commission of delinquent acts by the child and the commission of the acts are shown to be the result of the encouragement, condonation, or approval; or

- Has committed abuse or neglect as described in subsections (a) through (e) such that a child who subsequently becomes part of the person's household is at substantial risk of one of those forms of abuse or neglect.

Reporting critical events or incidents:
A physician, nurse, dentist, optometrist, medical examiner, or coroner, or an employee of a county medical examiner's or coroner's office, or any other medical, emergency medical services, mental health, or allied health professional, member of the clergy including a Christian Science Practitioner or religious healer, school teacher, counselor, principal, assistant principal, school attendance officer, social or public assistance worker, substance abuse treatment staff, or childcare worker in a childcare center or foster care facility, foster parent, police or law enforcement officer, juvenile justice worker, undertaker, funeral home director or employee of a funeral home, persons responsible for processing films, computer technician, judge, or a volunteer non-attorney guardian ad litem serving on behalf of the South Carolina Guardian Ad Litem Program or on behalf of Richland County CASA must report in accordance with this section when in the person's professional capacity the person has received information which gives the person reason to believe that a child has been or may be abused or neglected.

If a person required to report has received information that in the person's professional capacity which gives the person reason to believe that a child's physical or mental health or welfare has been or may be adversely affected by acts or omissions that would be child abuse or neglect if committed by a parent, guardian, or other person responsible for the child's welfare, but the reporter believes that the act or omission was committed by a person other than the parent, guardian, or other person responsible for the child's welfare, the reporter must make a report to the appropriate law enforcement agency.

A person, including, but not limited to, a volunteer non-attorney guardian ad litem serving on behalf of the South Carolina Guardian Ad Litem Program or on behalf of Richland County CASA, who has reason to believe that a child's physical or mental health or welfare has been or may be adversely affected by abuse and neglect may report, and is encouraged to report, in accordance with this section.

Reports of child abuse or neglect may be made orally by telephone or otherwise to the county department of social services or to a law enforcement agency in the county where the child resides or is found.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

At the time of enrollment, the children/youth are informed of how to report abuse, neglect and exploitation by telephone or otherwise to the county department of social services (if a parent is the abuser) or to a law enforcement agency in the county where the child resides or is found (if the abuser is not a parent or acting in the place of a parent).

See S.C. Code Ann. § 63-7-450.
The Department of Social Services Protective Services shall inform all persons required to report abuse, of the nature, problem, and extent of child abuse and neglect and of their duties and responsibilities in accordance with State law. SCDSS, on a continuing basis, shall conduct training programs for Department staff and appropriate training for persons required to report.

SCDSS, on a continuing basis, shall inform the public of the nature, problem, and extent of the child abuse and neglect and of the remedial and therapeutic services available to children and their families. SCDSS shall encourage families to seek help consistent with Section 63-7-30.
SCDSS, on a continuing basis, shall actively publicize the appropriate telephone numbers to receive reports of suspected child abuse and neglect, including the twenty-four hour, statewide, toll-free telephone service and respective numbers of the county department offices.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

All reports of crimes, abuse, neglect or exploitation should be made to those State agencies having statutory authority to receive reports and investigate allegations of suspected abuse, neglect and exploitation as described in be S.C. Code Ann. § 63-7-10 et seq.

All critical events or incidents that are discovered to have occurred under the purview of PCSC waiver providers/staff are reported upon discovery to the appropriate entities, by the person who discovered the incident, as well as reported to SCDHHS PCSC waiver staff within 24 hours of the report made to the appropriate entity. Those incidents that rise to the level of a crime against one of the waiver participants are reported immediately to law enforcement. Notification should be made to SCDHHS PCSC waiver staff within 24 hours of the report to Law Enforcement. If the crime reported was alleged to have been committed by a staff person, volunteer or contracted employee, that person will not be permitted to work or volunteer with waiver participants until/unless charges are dropped or resolved for the protection of the youth receiving services. Those incidents that rise to the level of an allegation of abuse, neglect or

exploitation is immediately reported to SCDSS upon the discovery of the incident. Notification should be made to SCDHHS PCSC waiver staff within 24 hours of the report to SCDSS. If the allegation is made against a staff person, volunteer or contracted employee, that child/youth will not be permitted to work or volunteer unsupervised with waiver participants until SCDSS completes their investigation with no substantiated finding of abuse. All other critical incidents should be reported as required to the appropriate entity and reported to SCDHHS within 48 hours of the original report to ensure the safety of youth in the waiver.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The county department of social services or to a law enforcement agency in the county where the child resides or is found. See S.C. Code Ann. § 63-7-10 et seq.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

a. Use of Restraints ***(select one):(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)***

☐	**The State does not permit or prohibits the use of restraints** Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:
	The Department of Health and Human services and the Social Services (SCDSS) conducts yearly licensure reviews for licensed facilities including Therapeutic Foster Care homes. SCDSS, Out of Home Abuse and Neglect Division (OHAN) investigates reports of any abuse or neglect by licensed facilities. Such reports can be made anonymously.
☒	**The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii:

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

b. Use of Restrictive Interventions

☐	**The State does not permit or prohibits the use of restrictive interventions** Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:
	1 Department of Social Services (SCDSS) conducts yearly licensure reviews. 2 SCDSS; Out of Home Abuse and Neglect Division (OHAN), investigates reports of any abuse or neglect by licensed facilities. Such reports can be made anonymously.
☒	**The use of restrictive interventions is permitted during the course of the delivery of waiver services.** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

c. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

☐	**The State does not permit or prohibits the use of seclusion** Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:
	1. Department of Social Services (DSS)- conducts yearly licensure reviews. 2. DSS; Out of Home Abuse and Neglect Division (OHAN) - investigates reports of any abuse or neglect by licensed facilities. Such reports can be made anonymously. 3. Referring State Agencies – All child serving state agencies are required to monitor and follow-up at least monthly, with each child they have placed in a licensed facility. Licensed facilities are required to file a Critical Incident (CI) report to the referring state agency within 24 hours from the time of the incident. CIs include any emergency safety intervention. 4. DHHS Quality Reviews are conducted annually or as needed. Reviews of respite provided in Therapeutic Foster Care homes will include a review of any use of seclusion reported to be used for children while participating in PCSC Waiver Respite.
☒	**The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

☒	**No**. **This Appendix is not applicable** *(do not complete the remaining items)*
☐	**Yes**. **This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Monitoring of medication for waiver youth who live in Therapeutic Foster care placements are done by SCDSS as part of the annual licensure renewal.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and (c) the State agency (or agencies) that is responsible for follow-up and oversight.

The South Carolina Department of Social Services is responsible for licensing foster homes. As a part of the licensing process and as part of the on-going re-licensing reviews, residential providers must have policies/procedures, safety mechanisms, training, and internal quality assurance oversight of their program's medication regime.

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one*:

☒	Not applicable (*do not complete the remaining items*)
☐	**Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Respite provided in the child/youth's home. Medication may be administered during respite hours in the child's home by the respite worker. Medications, including controlled substances, medical supplies, and those items necessary for the rendering of first aid shall be properly managed in accordance with State, Federal, and local laws and regulations. Such management shall address the securing, storing, and administering of medications, medical supplies, first aid supplies, and biologicals, their disposal when discontinued or expired, and their disposition at discharge of a participant.

iii. Medication Error Reporting. *Select one of the following:*

☐	**Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).** *Complete the following three items:*
	(a) Specify State agency (or agencies) to which errors are reported:
	Critical Incidents including medication errors requiring treatment from an outside entity (i.e., Physician's Office, Urgent Care, or Emergency Room) must be reported to the referring state agency (e.g., Continuum of Care, Department of Social Services, or DHSS), within 24 hours from the time of the critical incident. Staff providing waiver Respite services must be trained on what to do if there is an error in medication administration. If it was an error in documentation, the error should be corrected as required and communicated to the appropriate Supervisor. If the error was in the administration of the medication such as a missed does or an over dose of medication, the staff should immediately contact a medical professional who can determine what course of action needs to be taken to ensure the safety of the child. Adverse reactions to med errors must be documented. Med errors must be communicated upon staff change over to ensure continuity of care. The program policy must include written procedures for documenting and communicating medication error(s). The provider must make every effort to notify all medical personnel who prescribe and/or administer medications to a child about any medications the child is currently taking and of any changes in the child's medication since he or she was last seen by the medical provider.
	(b) Specify the types of medication errors that providers are required to *record:*
	Any error in administering medication that results in the med given to the child in a way that it was not intended by the prescribed by the clinician.
	(c) Specify the types of medication errors that providers must *report* to the State:
	Any medication error that results in adverse effects which are detrimental and cause harm to the youth's health and safety must be documented in the youth's file. Those medication errors that result in the need to seek emergency medical attention or contact law enforcement must be reported as a critical incident.
☑	**Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.** Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The South Carolina Department of Social Services is responsible for conducting the initial licensing of foster homes and licensure renewals every two years. As a part of the licensing process, and as part of the on-going re-licensing reviews, residential providers must have policies/procedures, safety mechanisms, training, and internal quality assurance oversight of their program's medication regimen. If a program is found to be out of compliance, SCDSS administers a quality improvement notification. The provider must respond within a certain

timeframe with a detailed plan addressing how they will change policies/procedures to address the deficiency. SCDSS conducts unannounced site visits during this period as well, to ensure appropriate corrective action has taken place and to monitor improvement. In addition, SCDSS has a memorandum of agreement with SCDHHS to ensure the exchange of information between the two agencies related to out-of-home placement services regarding critical incidents or issues that may affect licensure and therefore, Medicaid enrollment, and to establish procedures for coordinating and collaboration between SCDHHS and SCDSS. This procedure applies to medication monitoring and would apply to all children placed in the waiver. It is the intent of SCDHHS and SCDSS to utilize the shared information to support program maintenance, policy planning and implementation of quality and evidenced based processes for Medicaid provider enrollment and licensing purposes. SCDHHS monitors medications administered annually for waiver participants who receive respite services in Therapeutic Foster Care homes. SCDHHS utilizes annual quality reviews to evaluate if the CFT/TCM has monitored medication management for youth in the waiver. Annual quality reviews evaluate if the services provided met the expected outcomes concerning medication management.

Referring State Agencies - All child serving State agencies are required to monitor and follow-up at least monthly with each child they have placed in a licensed out-of-home placement. This monitoring process includes a review of medications and medication administration.

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Health and Welfare**
The State demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-assurances:

a. Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

***i.* Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed

statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	*Number and percent of participants (and/or family or guardian) who received information on how to report abuse, neglect, exploitation and other reportable incidents. .* *Numerator: Number of participants documented to have received information/education on how to report abuse, neglect, exploitation and other reportable incidents* *Denominator(n): Total number of participants*
Data Source *(Select one) (Several options are listed in the on-line application):* ***Other***	
If 'Other' is selected, specify:	
Phoenix Data system	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⊏ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval =*
	⌙ *Other Specify:*	⌙ *Annually*	
		⊏ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*	
			⌙ *Other Specify:*

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⊏ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other*	⊏ *Annually*

Specify:	
	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

Performance Measure:	*Proportion of Wraparound facilitator/TCMs who have had required training in abuse, neglect, exploitation and other reportable incidents. Numerator: Number of Wraparound facilitator/TCMs documented to have received training in abuse, neglect, exploitation and other reportable incidents. Denominator: Total number of Wraparound facilitator/TCMs*

Data Source *(Select one) (Several options are listed in the on-line application):*
Other

If 'Other' is selected, specify:

Phoenix Data system

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⌧ *State Medicaid Agency*	⌙ *Weekly*	⌧ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval =*
	⌙ *Other Specify:*	⌙ *Annually*	
		⌧ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*	
			⌙ *Other Specify:*

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⌧ *State Medicaid Agency*	⌙ *Weekly*

⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other Specify:*	⌐ *Annually*
	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

Performance Measure:	*Number and percent of deaths with a determined need for investigation that were investigated.* *Numerator: Number of deaths with a determined need for investigation that were investigated* *Denominator: Total number of deaths with a determined need for investigation*
Data Source *(Select one) (Several options are listed in the on-line application):* ***Other***	
If 'Other' is selected, specify:	
Reports related to abuse, neglect, exploitation (ANE), unexplained deaths, critical incidents, restrictive interventions;.	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⌐ *State Medicaid Agency*	⌙ *Weekly*	⌐ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval =*
	⌙ *Other Specify:*	⌙ *Annually*	
		⌐ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*	
			⌙ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⊏ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other Specify:*	⊏ *Annually*
	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

Performance Measure:	*Number and percent of substantiated cases of abuse, neglect and exploitation (ANE) where recommended actions to protect health and welfare were implemented* *Numerator: Number of Cases with actions* *Denominator: Total number of cases)*
Data Source *(Select one) (Several options are listed in the on-line application):* ***Record reviews, on-site***	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⊏ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval =*
	⌙ *Other Specify:*	⌙*Annually*	
		⊏ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*	
			⌙ *Other Specify:*

Data Source *(Select one) (Several options are listed in the on-line application):* ***Other***				
If 'Other' is selected, specify:				
Incident reporting data sheet - incident management, generates data, performs reporting, etc.				
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*	
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⊏ *100% Review*	
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*	
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval =*	
	⌙ *Other Specify:*	⌙ *Annually*		
		⊏ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*	
		⌙ *Other Specify:*		
			⌙ *Other Specify:*	

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⊏ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other Specify:*	⊏ *Annually*
	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

Performance Measure:	*No. and percent of critical incidents reported timely, aggregated and by incident type- Abuse, Neglect, and Exploitation (ANE) and Misappropriation of Funds.* *Numerator: Number of Timely critical incidents* *Denominator: Total critical incidents*
Data Source *(Select one) (Several options are listed in the on-line application):* ***Record reviews, off-site***	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⊏ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval =*
	⌙ *Other Specify:*	⊏ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*	
			⌙ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⊏ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other Specify:*	⊏ *Annually*
	⌙ *Continuously and Ongoing*
	⌙ *Other*

	Specify:

Add another Performance measure (button to prompt another performance measure)

b. Sub-assurance: The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	*Number and percent of critical incident reviews/investigations that were completed as specified in the State Policy.* *Numerator: Number of critical incident reviews/investigations that were completed as specified in the State Policy* *Denominator: Total number of critical incident reviews/investigations*
Data Source *(Select one) (Several options are listed in the on-line application):* Other.	
If 'Other' is selected, specify:	

Critical Incident Log			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⊏ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval =*
	⌙ *Other Specify:*	⊏ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other*	

		Specify:		
				⌙ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⊏ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other Specify:*	⊏ *Annually*
	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

Performance Measure:	*No. and percent of participants who had a prevention plan developed as a result of the Abuse Neglect and Exploitation (ANE)/ Misappropriation of Funds (MoF) or other Critical Incident.* *Numerator: Participants with prevention plan developed due to Critical Incident* *Denominator: Total participants with ANE or MoF or Critical Incident*
Data Source *(Select one) (Several options are listed in the on-line application):* Other	
If 'Other' is selected, specify: Reports related to abuse, neglect, exploitation (ANE), unexplained deaths, critical incidents, restrictive intervention application;	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⊏ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval =*
	⌙ *Other*	⊏ *Annually*	

	Specify:			
		⌙ *Continuously and Ongoing*		⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*		
				⌙ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⊏ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other Specify:*	⊏ *Annually*
	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

Performance Measure:	*No. and percent where a prevention plan (PP) was developed because of unapproved restraint, seclusion or other restrictive interventions. Numerator: Number of PP developed Denominator: Total instances of unapproved interventions)*		
Data Source *(Select one) (Several options are listed in the on-line application):* Other.			
If 'Other' is selected, specify:			
If 'Other' is selected, specify: Reports related to abuse, neglect, exploitation (ANE), unexplained deaths, critical incidents, restrictive intervention application;			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⊏ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence*

				Interval =
	⌙ *Other Specify:*	⌐ *Annually*		
		⌙ *Continuously and Ongoing*		⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*		
				⌙ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⌐ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other Specify:*	⌐ *Annually*
	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

c. Sub-assurance: The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	The following performance measure has been added: *Number and percent of unauthorized uses of restrictive interventions that were properly reported. Numerator: Number of unauthorized uses of restrictive interventions.*

	Denominator: Total number of reportable incidents
Data Source *(Select one) (Several options are listed in the on-line application):* Other.	
If 'Other' is selected, specify: Reports related to restrictive intervention application;	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⊏ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval =*
	⌙ *Other Specify:*	⊏ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*	
			⌙ *Other Specify:*

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⊏ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other Specify:*	⊏ *Annually*
	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

Performance Measure:	*Number and percent of participants identified as needing medication administration and having a medication admin plan* *Numerator: Identified participants with Medication administration plan*

	Denominator:Total reviewed records with medication administration identified
Data Source *(Select one) (Several options are listed in the on-line application):* Other.	
If 'Other' is selected, specify: Reports related to abuse, neglect, exploitation (ANE), unexplained deaths, critical incidents, restrictive intervention application;	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⊏ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval =*
	⌙ *Other Specify:*	⊏ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*	
			⌙ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⊏ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other Specify:*	⊏ *Annually*
	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

d. Sub-assurance: The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	*Number and percent of HCBS beneficiaries who received physical exams consistent with State of South Carolina 1915(c) program HCBS policy.* *Numerator: HCBS beneficiaries who received annual physical exams* *Denominator: HCBS beneficiaries*
Data Source *(Select one) (Several options are listed in the on-line application):* ***Other***	
If 'Other' is selected, specify: ***Service claims data regarding primary care physical exams.***	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⌙ *State Medicaid Agency*	⌙ *Weekly*	⊏ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval =*
	⌙ *Other Specify:*	⊏ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*	
			⌙ *Other Specify:*

Data Source *(Select one) (Several options are listed in the on-line application):* Other.
If 'Other' is selected, specify: Wraparound facilitator/TCM monitoring visit data.

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation :*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⊏ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval =*
	⌙ *Other Specify:*	⊏ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*	
			⌙ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⊏ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other Specify:*	⊏ *Annually*
	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.*

When issues/problems/concerns are discovered by SCDHHS through formal quality review processes, the responsible party is notified by SCDHHS staff. SCDHHS staff identifies the problem, makes the responsible party aware of the problem, and ensures that they have appropriate information to correct the problem. SCDHHS staff formally issues a statement of deficiency requiring a corrective action plan (CAP). If SCDHHS deems the problem/issue/concern to cause imminent danger to the waiver operations or children/youth, SCDHHS notifies the responsible party and the responsible party is restricted from conducting waiver related supports and services until the issues are resolved and SCDHHS accepts the CAP. Once written notification is received, the CAP must be submitted within 30 days to SCDHHS. The corrective action plan addresses both immediate problems and identifies how the problems will be avoided in the future. SCDHHS reviews corrective action plans to ensure that they address the underlying issues/concerns. Failure to submit and implement a corrective action plan may result in being excluded from Medicaid.

When issues/problems/concerns are discovered by SCDHHS through informal processes, the responsible party is contacted by SCDHHS staff. SCDHHS staff identifies the problem, makes the responsible party aware of the problem and ensures that they have appropriate information to correct the problem. If SCDHHS deems the problem/issue/concern to cause imminent danger to the waiver operations or children/youth, SCDHHS issues a formal notice of deficiency and notifies the responsible party. If the issue/problem/concern is of a less serious nature, SCDHHS staff documents the contact and the request for correction to ensure that there is timely and appropriate follow up. The responsible party is given an opportunity to correct the problem informally and submit corrections to SCDHHS staff. If the problem is not addressed in a timely way, SCDHHS staff formally issue a statement of deficiency requiring a corrective action plan. Once written notification is received, the CAP must be submitted within 30 days to SCDHHS. The corrective action plan addresses both immediate problems and identifies how the problems will be avoided in the future. SCDHHS reviews corrective action plans to ensure that they address the underlying issues/concerns. Failure to submit and implement a corrective action plan may result in being excluded from Medicaid.

ii. **Remediation Data Aggregation**

	Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies)*
	☐ **State Medicaid Agency**	☐ **Weekly**
	☐ **Operating Agency**	☐ **Monthly**
	☐ **Sub-State Entity**	☐ **Quarterly**
	☐ **Other** Specify:	☐ **Annually**
		☐ **Continuously and Ongoing**
		☐ **Other** Specify:

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

☐	**No**
☑	**Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The remediation activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

H.1 Systems Improvement

a. **System Improvements**

i. Describe the process(es) for trending, prioritizing and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The PCSC waiver's quality management strategy aims to identify positive and negative trends which allows for necessary adjustments to enhance the overall performance of the system. Trends identified through the Quality Improvement Strategy have allowed South Carolina to make system design changes to better meet the needs of the youth in the waiver, address unforeseen conflicts of interest, improve the quality of services being provided to waiver participants and make adjustments to our quality improvement process to better evaluate provider compliance.

Quality reviews have allowed us the opportunity to evaluate aggregated waiver data. This has supported the State to take necessary actions to address areas of concern, improve systems and enhance outcomes for waiver participants.

SCDHHS is continuously reviewing and updating its Quality Management System processes to ensure it is responsive to the quality assurances. SCDHHS has developed formal processes and activities in this new waiver to look at the quality of the services being provided. These activities use a standard protocol to evaluate each provider and service area consistently. These protocols allow SCDHHS to identify trends, prioritize and implement system improvements as needed. System improvement activities are designed to ensure that based on the performance measures, all six CMS assurances are addressed (i.e. freedom of choice; initial and annual level of care evaluations; continued eligibility; health and safety; service provision and utilization; person-centered plan development; staff qualifications and training; provider compliance with administrative requirements and; continued monitoring of cost neutrality).

Information collected during these reviews is analyzed and utilized to implement improvements within the program. Prioritizing and implementing system improvements is based on the severity of identified problem(s) and the frequency of duplicated errors. Waiver assurances that are below 100% and issues that the data shows are a statewide problem (a trend) are top priority and would result in immediate action to improve the system. Systems Improvement for waiver assurances below 100% may involve the following: 1. Revisions to the training program 2. Revision of policy and procedure for clarification 3. Modifications to expand/improve the review process and data collection.

Statewide problems, even if the issue discovered is not one of the six assurances, becomes a top priority based on the prevalence of the problem. Systems improvement for statewide trends can be addressed through any of the following: 1. Revisions to the training program 2. Revision of policy and procedure for clarification 3. Modifications to improve the review process and data collection.

ii. System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of monitoring and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement**	☑ **Annually**

Committee	
☐ **Other** Specify:	☐ **Other** Specify:
	As Needed.

b. **System Design Changes**

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The following process is used to monitor and analyze data and system design. SCDHHS waiver staff receives the person-centered plan, budgets, authorizations and level of care for each youth enrolled in the waiver on a quarterly basis. Prior to SCDHHS authorizing services, the person-centered plan, budget and the level of care are reviewed by SCDHHS waiver staff to ensure quality and compliance with rules, regulations and waiver standards. Services are not authorized by SCDHHS until established standards are met. To ensure that all person-centered plans and levels of care are completed timely as required, a report is generated each quarter to show which person-centered plans and levels of care are past due or due soon. Providers are contacted immediately upon the discovery of a person-centered plan or level of care being found to be out of compliance. A request is made for these documents, and if they are not submitted within a reasonable time frame, a formal request letter is sent to the provider requesting the documents and a corrective action plan.

Offsite administrative review are completed in conjunction with an onsite program review for each provider on an annual basis. Providers are required to provide a list of all staff who have provided PCSC waiver services prior to the administrative review so in review of records it can be determined if all staff members have met the requirements for the job they are performing. A service utilization report is generated prior to the onsite review so paid claims can be evaluated based on the performance measures.

The offsite review focuses on administrative requirements such as staff credentials, staff qualifications, staff training, employee screenings, employee background checks, other provider organization requirements and physical location requirements.

The onsite review focuses on service provision requirements such as service delivery in accordance with the person-centered plan, budget and authorizations for services; billable and appropriate service activities, continued eligibility for services; health and safety; cost neutrality.

Unless otherwise noted in the Performance Measures in this waiver, the annual review, conducted by SCDHHS waiver staff, analyzes a 5% sample (or at least one child/youth file review, whichever is more) of the children/youth. The annual review looks at documentation to support services provided within a specified time frame for each provider in each service area in regard to the performance measures established. If previous quarterly reviews or annual reviews have shown a provider to have been out of compliance, the sample may be expanded to ensure that the issues previously discovered have been addressed. If a major concern is discovered during the course of the annual review the sample size and scope of the review may be expanded. Any concerns identified by the standard review protocol are identified and reported to the provider. Any issues that are contradictory to the CMS assurances are communicated at the time of the review; result in immediate action to correct the problem and require the provider to submit a Correction Action Plan to ensure that the problem does not reoccur. An annual review can be initiated at any time that a concern in raised. Any discovery of possible fraud is reported to program integrity.

A report compiling all of these pieces of information is created for each provider when the reviews are completed. Providers are given the report upon its completion. If significant issues are identified, the provider is asked to submit a Corrective Action Plan to address the concerns discovered.

When a full cycle of provider reviews has been completed, an annual report is developed by SCDHHS PCSC waiver staff. This report encompasses all the providers and identifies trends and needed system improvements. SCDHHS evaluates the findings in this report and makes necessary changes and improvements to the waiver.

Problems, issues or concerns that have been identified as a result of the quality improvement activities are addressed through policy change or revision; training; and modifications/changes to the data collection process. If the issues are discovered during annual reviews or during quarterly reviews, on the spot re-education of child/youth providers occurs to ensure that the provider has the information they need stay in compliance. In addition, trends that become evident prior to a full cycle of reviews being completed are addressed as soon as possible as appropriate. In these cases, the policy is reviewed to determine if clarification might be needed. Exploration into the quality improvement system itself is also analyzed to determine if the approach needs to be adjusted.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Appendix I: Financial Accountability

review cycle when it is discovered that the quality improvement strategy needs changed, the issue is evaluated and discussed by SCDHHS to adjust it as necessary. One way to discover areas that are not being fully addressed by the quality improvement strategy that we have utilized in the past and will continue to utilize going forward, is seeking out feedback from the youth, families, peer navigators, providers, state agencies, and other stakeholders. In this way we get experience, advocacy and data to back up the feedback which allows South Carolina to make sound and appropriate adjustments to the quality improvement strategy.

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Under the Single Audit Act, the DHHS is required to secure an independent audit of the entirety of its programs through the State Auditor's office as part of the Single Audit Act. The most recent DHHS audit can be found at: http://osa.sc.gov/Reports/stateengagements/Documents/YearEnded2016/J0216.pdf

SCDHHS PCSC waiver staff conducts annual administrative and program reviews to evaluate the quality of the services and ensure that providers are complying with PCSC waiver Policies and Procedures.

In addition, SCDHHS also conducts quarterly reviews of the person-centered plan for each waiver child/youth with 100% of plans being reviewed annually. When issues of concern are discovered on-site regarding insufficient documentation to bill for services an attempt is made to obtain supporting documentation from the provider. Special reviews are conducted as needed when issues of concern arise. If the provider cannot produce the supporting documentation within a reasonable time frame, SCDHHS waiver Staff contact SCDHHS Program Integrity and refer the concern to them for further investigation.

SCDHHS will annually analyze 100% of paid claims in a desk review in regard to service utilization and cost. When issues or concerning trends are discovered during the course of their research, those issues are reported to SCDHHS waiver staff for further evaluation and investigation into the concern. If SCDHHS's evaluation of the situation determines that claims may have been inappropriate or excessive billings SCDHHS waiver staff contact Program Integrity for further investigation.

In general, the audit review entails the review of applicable program policy, review of paid and/or rejected claims information, and review of the service plan and associated documents filed in support of the claim submission.

The Division of Program Integrity at SCDHHS responds to complaints and allegations of inappropriate or excessive billings by Medicaid providers, and also collects data and analyzes providers in order to identify billing exceptions and deviations. In this capacity, Program Integrity may audit payments to

PCSC waiver service providers. Issues that involve fraudulent billing by providers are turned over to the Medicaid Fraud Control Unit in the South Carolina Attorney General's Office. In addition, the Division of Audits reviews SCDHHS contracts with external entities in order to ensure that contract terms are met and only allowable costs are charged.

SC conducts Program Integrity audits in the following manner in order to protect against fraudulent activity and to ensure fiscal integrity:

- Provider research is conducted. Research of the provider may include one or more of the following: Identification of NPI and affiliations, Secretary of State, Background Checks, MMIS Provider Enrollment Information, Review of Contract and/or Provider Enrollment Records;
- The Division of Program Integrity employs the use of investigators to conduct interviews of providers, complainants and beneficiaries. Targeted BEOMBs are also employed to survey a random sample, or all of a particular provider's beneficiary base for confirmation of services rendered.
- Applicable Program Policies are identified and reviewed.
- Claims research is conducted by the assigned Program Integrity Reviewer and/or Surveillance Utilization Staff.
- A review time period is established.
- A random sample of claims is conducted as well as additional exception items of interest.
- The reviewer initiates a request for provider records. Upon receipt those records are reviewed by the Program Integrity Reviewer to ensure that the documentation clearly indicates the medical need for the services.
- After the initial review is completed, a findings letter is generated and supported with pertinent data and analysis reports. The provider is given 10 days to respond and provided an opportunity to request an informal conference to discuss the review findings.
- After the 10 day letter, a final determination letter is generated which includes appeal rights, instructions for filing an appeal and the timeframe for which to file an appeal.
- If there is an indication of fraudulent billing at any point in the review process, the case is referred to the MFCU.
- Regularly scheduled communication and feedback will continue between PI and MFCU until a determination and/or convictions or fraud of civil action is final.
- In situations where a credible allegation of fraud exists, PI must suspend the provider's payments and issue appropriate notifications as established by Program Integrity Policies and Procedures.
- If the provider fails to abide by the PI recoupment, the provider may be subject to Termination for Cause due to non-payment of a PI established recoupment.

Once billing exceptions and deviations are identified, the following steps are followed:

- A review time-period is selected and a random sample is generated. In addition to the random sample selection, additional records may be selected from exceptions and deviations discovered on SUR reports.
- Reviewer requests and review records. Program Integrity may conduct any one of the following types of review:
  - Desk Review - A Desk Review occurs when the Program Integrity Reviewer requests the provider records but does not conduct an on-site review at the provider's place of business.
  - Onsite – An onsite occurs whenever there are strong indicators for waste, fraud and abuse.
  - Provider Self Review – In a provider self-review the provider performs a self-review and notifies the Department of the results.
  - U-Owe-Us – Data profile and analysis that can be used for provider notification and recoupment. This type of review does not typically require evaluation of the medical record. The provider is provided the opportunity to conduct his/her own review and submit information that may result in revision of the original amount identified by Program Integrity.

- A review may occur upon receipt of a valid complaint from any source and/or selection as a result of Surveillance Utilization Exception Reporting.
- After an overpayment is identified, PI contacts the Fiscal Operations to initiate collection activities to recoup erroneous payment(s). Fiscal Operations contacts the provider to recover the overpayment and/or set up a payment plan, if appropriate. If the provider misses two consecutive payments, Fiscal refers the matter back to PI to begin termination proceedings based on non-payment of a recoupment identified by a Program Integrity review.

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Financial Accountability Assurance**
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-assurances:

a Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

a.i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	*The percent of authorized HCBS waiver claims submitted that were paid.* *Numerator: Total number of paid waiver claims*

	Denominator(n): Total number of submitted waiver claims (with duplicates removed to account for multiple submissions)
***Data Source** (Select one) (Several options are listed in the on-line application): Other*	
If 'Other' is selected, specify:	
MMIS system.	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⌙ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⊏ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⊏ *Representative Sample; Confidence Interval = 95%*
	⌙ *Other Specify:*	⊏ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*	
			⌙ *Other Specify:*

Add another Data Source for this performance measure

***Data Source** (Select one) (Several options are listed in the on-line application):* Record reviews, off-site	
If 'Other' is selected, specify:	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⊏ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval = 95%*
	⌙ *Other Specify:*	⌙ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⊏ *Other*	

		Specify: As needed		
				⌙ *Other Specify:*

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⊏ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other Specify:*	⊏ *Annually*
	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

Performance Measure:	*Number and percent of HCBS waiver claims paid using the correct rate.* *Numerator: Total number of paid claims with a rate that is less than or equal to the Medicaid maximum rate for the service.* *Denominator(n): Total number of approved waiver claims (with duplicates removed to account for multiple submissions)*
Data Source *(Select one) (Several options are listed in the on-line application):Other*	
If 'Other' is selected, specify:	
MMIS system	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⌙ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⊏ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⊏ *Representative Sample; Confidence Interval = 95%*
	⌙ *Other Specify:*	⊏ *Annually*	

		⌙ *Continuously and Ongoing*		⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*		
				⌙ *Other Specify:*

Add another Data Source for this performance measure

Data Source *(Select one) (Several options are listed in the on-line application):*
Record reviews, off-site
If 'Other' is selected, specify:

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⌧ *State Medicaid Agency*	⌙ *Weekly*	⌧ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval = 95%*
	⌙ *Other Specify:*	⌙ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌧ *Other Specify: As needed*	
			⌙ *Other Specify:*

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⌧ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other Specify:*	⌧ *Annually*
	⌙ *Continuously and Ongoing*

	⌙ *Other Specify:*

Performance Measure:	*Number and percent of claims paid for children/youths who were enrolled in the HCBS waiver program on the date of services.* *Numerator: Number of claims denied for eligibility reasons* *Denominator(n): Total number of approved waiver claims*
Data Source *(Select one) (Several options are listed in the on-line application): Other*	
If 'Other' is selected, specify:	
MMIS system	

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⌙ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⊏ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⊏ *Representative Sample; Confidence Interval = 95%*
	⌙ *Other Specify:*	⊏ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*	
			⌙ *Other Specify:*

Add another Data Source for this performance measure

Data Source *(Select one) (Several options are listed in the on-line application):* ***Record reviews, off-site***			
If 'Other' is selected, specify:			
	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

	⊏ *State Medicaid Agency*	⌙ *Weekly*	⊏ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval = 95%*
	⌙ *Other Specify:*	⌙ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⊏ *Other Specify: As needed*	
			⌙ *Other Specify:*

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⊏ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other Specify:*	⊏ *Annually*
	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

Performance Measure:	Number and percent of HCBS waiver claims submitted supported by required documentation at time of review. *Numerator: Number of claims reviewed that had all required documentation* *Denominator: Total number of claims reviewed*
Data Source *(Select one) (Several options are listed in the on-line application):* ***Record reviews, off-site***	
If 'Other' is selected, specify:	

	Responsible Party for	***Frequency of data***	***Sampling Approach***

	data collection/generation *(check each that applies)*	***collection/generation:*** *(check each that applies)*	*(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⊏ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval = 95%*
	⌙ *Other Specify:*	⌙ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⊏ *Other Specify: As needed*	
			⌙ *Other Specify:*

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*
⊏ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other Specify:*	⊏ *Annually*
	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

b. Sub-assurance: The State provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	Number/percentage of rates that remain consistent with the approved rate methodology throughout the waiver cycle. *Numerator: number of rates that are set consistent with the rate methodology in the waiver* *Denominator: Total number of rates*
Data Source *(Select one) (Several options are listed in the on-line application):* ***Other***	
If 'Other' is selected, specify:	

Rate setting methodology

	Responsible Party for data collection/generation *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	⊏ *State Medicaid Agency*	⌙ *Weekly*	⊏ *100% Review*
	⌙ *Operating Agency*	⌙ *Monthly*	⌙ *Less than 100% Review*
	⌙ *Sub-State Entity*	⌙ *Quarterly*	⌙ *Representative Sample; Confidence Interval =*
	⌙ *Other Specify:*	⊏ *Annually*	
		⌙ *Continuously and Ongoing*	⌙ *Stratified: Describe Group:*
		⌙ *Other Specify:*	
			⌙ *Other Specify:*

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis *(check each that*	***Frequency of data aggregation and analysis:*** *(check each that*

applies	*applies*
⊏ *State Medicaid Agency*	⌙ *Weekly*
⌙ *Operating Agency*	⌙ *Monthly*
⌙ *Sub-State Entity*	⌙ *Quarterly*
⌙ *Other Specify:*	⊏ *Annually*
	⌙ *Continuously and Ongoing*
	⌙ *Other Specify:*

Add another Performance measure (button to prompt another performance measure)

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.*

When issues/problems/concerns are discovered by SCDHHS through formal quality review processes, the responsible party is notified by SCDHHS staff. SCDHHS staff identifies the problem, makes the responsible party aware of the problem, and ensures that they have appropriate information to correct the problem. SCDHHS staff formally issues a statement of deficiency requiring a corrective action plan (CAP). If SCDHHS deems the problem/issue/concern to cause imminent danger to the waiver operations or children/youth SCDHHS notifies the responsible party and the responsible party is restricted from conducting waiver related supports and services until the issues are resolved and SCDHHS accepts the CAP. Once written notification is received, the CAP must be submitted within 30 days to SCDHHS. The corrective action plan addresses both immediate problems and identifies how the problems will be avoided in the future. SCDHHS reviews corrective action plans to ensure that they address the underlying issues/concerns. Failure to submit and implement a corrective action plan may result in being excluded from Medicaid.

When issues/problems/concerns are discovered by SCDHHS through informal processes, the responsible party is contacted by SCDHHS staff. SCDHHS staff identifies the problem, makes the responsible party aware of the problem, and ensures that they have appropriate information to correct the problem. If SCDHHS deems the problem/issue/concern to cause imminent danger to the waiver operations or children/youth, SCDHHS issues a formal notice of deficiency and notifies the responsible

party. If the issue/problem/concern is of a less serious nature, SCDHHS staff documents the contact and the request for correction to ensure that there is timely and appropriate follow-up. The responsible party is given an opportunity to correct the problem informally and submit corrections to SCDHHS staff. If the problem is not addressed in a timely way, SCDHHS staff formally issue a statement of deficiency requiring a corrective action plan. Once written notification is received, the CAP must be submitted within 30 days to SCDHHS. The corrective action plan addresses both immediate problems and identifies how the problems will be avoided in the future. SCDHHS reviews corrective action plans to ensure that they address the underlying issues/concerns. Failure to submit and implement a corrective action plan may result in being excluded from Medicaid.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	☐ **State Medicaid Agency**	☐ **Weekly**
	☐ **Operating Agency**	☐ **Monthly**
	☐ **Sub-State Entity**	☐ **Quarterly**
	☐ **Other** Specify:	☐ **Annually**
		☐ **Continuously and Ongoing**
		☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

☐	**No**
☐	**Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

APPENDIX I-2: Rates, Billing and Claims

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The SCDHHS, Bureau of Reimbursement Methodology and Policy, is responsible for the development of waiver service payment rates. The SCDHHS allows the public to offer comments on waiver rate changes and rate setting methodology either through Medical Care Advisory Committee meetings, public hearings, or through meetings with association representatives.

Waiver service rates are established based upon the projected costs of the service to be provided. SCDHHS, Bureau of Reimbursement Methodology perform financial reviews to ensure that funding provided by the South Carolina General Assembly was appropriately expended by providers of these services.

Except as otherwise noted in the State Plan, the State-developed fee schedule is the same for both governmental and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the State's website at: XXXX. The agency's fee schedule rate was set as of July 1, 2017 and is effective for services provided on or after that date.

Fee schedule rates for all services except non-medical transportation and Individual goods and services were developed using a market-based pricing approach. This methodology includes a review of the service definitions, applicable South Carolina regulations, provider qualifications and licensure requirements, required training and certification, staffing requirements and discussions regarding the vision and expectations for service delivery. Allowable cost components were identified to reflect costs that are reasonable, necessary and related to the delivery of service under the 1915(c) waiver. Market-based research was performed to inform the development of the assumptions for the various cost components, along with discussions regarding the State's expectations of service delivery, and these assumptions were then used to model rates for each service. The Bureau of Labor Statistics was the primary data source utilized. Actual provider costs were not used in the development of the fee schedule rates or the development of the modeling assumptions.

We have provided more detail below on the sources reviewed, cost components considered and assumptions used to develop the fees for the 1915(c) waiver services. A market-based pricing approach was used to develop the fees for the waiver services. The State compared the fees developed under the market-based approach to fees in place for similar services in the former CHANCE waiver and other states.

The following list outlines the major components of the market-based approached and assumptions modeled in the fee schedule development process. The detailed assumptions are considered confidential and for internal use only by SC DHHS.

- Direct expenses – Direct care salary expenses were taken from Bureau of Labor Statistics (BLS) wage survey for the type of staff required to deliver the services as indicated in the service definitions. The positions vary by service, but generally include counselors, home care aides, psychologists, social workers, and social and/or human service assistants. The

hourly salary assumptions ranged from $9 to $52 per hour based on the service and applicable education requirements.

- Employee Related Expenses (ERE) –This category includes ERE the provider is responsible for on behalf of the staff hired to deliver, or oversee the delivery of, the waiver services. This includes items such as the employer's portion of health insurance, worker's compensation, employer taxes (FUTA/SUTA and FICA), disability insurance and paid time off. These assumptions were based on market research from publically available sources such as BLS as well as discussions with SC DHHS.
- Program-Related expenses – This category includes salary expense for supervisory staff or other program specialists as defined by the service. It also includes expenditures incurred by the provider through the delivery of the service that are not directly billable. This methodology includes consideration for employee training and certification, staff travel and supply costs, as required by service.
- Non-Benefit expenses – This category includes consideration for general administrative expenses such as administrative staff salaries, administrative building costs, insurance and IT needs. This assumption was established at 10% of overall costs for all services.
- Productivity – These assumptions were built based on productivity expectations for staff delivering the service. The range of productivity assumptions was from 3.5 to 6.5 hours per day, varying depending on the service.

A unit of service is defined according to the Healthcare Common Procedure Coding System (HCPCS) approved code set consistent with the National Correct Coding Initiative.

While there are no tiered rates, the evidence-based services reflect the higher costs of providing the services in fidelity with the national practices including certification, more extensive training, lower caseloads, more travel, and higher provider qualifications.

Individual directed goods and services are the only self-directed services and there is not an agency directed model of these services so there is no difference in rate setting. These services are reimbursed based on the price paid by the consumer/FMS for the service (i.e., the price of the good).

Non-Medical transportation is a negotiated rate with the state's enrollment broker.

The waiver service rates are not updated annually. The State will monitor rate sufficiency using the following techniques and amend the waiver if a rate methodology change is warranted.

To monitor for rate sufficiency, the following approaches will be taken under the future waiver period with each waiver renewal; any time an access complaint is received from a provider or beneficiary; or if there is a lack of provider capacity for a service needed by a child:

- Analyze and incorporate feedback from stakeholders. This approach includes evaluating feedback from individuals, families, independent case managers, advocacy groups and providers about the adequacy of direct service providers and collecting data on fair hearings, complaints and grievances related to lack of providers.
- Collect evidence from QIS D, sub-assurance d – This approach includes review of evidence related to the performance measures outlined in QIS D, sub-assurance d, which reviews whether services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the person-centered plan. This evidence includes the specific performance measure that assess whether services are delivered as outlined in the service plans by qualified individuals. The review starting in year four of the past waiver includes determining the reasons that individuals are not receiving services in accordance with

the service plan.

- Measure changes in provider capacity – This approach includes measuring the change in the number of the new providers and these providers' capacity as well as service utilization of enrollees and comparing the capacity and service utilization information to the previous years' data.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Provider billings flow directly from providers to the State's claim payment system. Providers may bill either by use of a CMS form 1500 or by the State's electronic billing system.

c. Certifying Public Expenditures *(select one)*:

☐	**No. State or local government agencies do not certify expenditures for waiver services.**
☒	**Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.** *Select at least one:*
	☐ **Certified Public Expenditures (CPE) of State Public Agencies.** Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)
	☐ **Certified Public Expenditures (CPE) of Local Government Agencies.** Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Upon submission of a claim to MMIS, payment is made to the provider only if the child/youth was Medicaid eligible on the date of service and there was an indicator in MMIS that the child/youth is enrolled in the waiver program. The Division of Program Integrity conducts post-payment reviews. These reviews sample claims and determine if services have been billed as authorized.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.

APPENDIX I-3: Payment

a. Method of payments — MMIS *(select one)*:

☐	**Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
☐	**Payments for some, but not all, waiver services are made through an approved MMIS.** Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
☐	**Payments for waiver services are not made through an approved MMIS.** Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
☐	**Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.** Describe how payments are made to the managed care entity or entities:

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

☐	**The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
☐	**The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
☐	**The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.** Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
☐	**Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.** Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

☐	**No**. **The State does not make supplemental or enhanced payments for waiver services.**
☒	**Yes**. **The State makes supplemental or enhanced payments for waiver services.** Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

☒	**No**. **State or local government providers do not receive payment for waiver services.** *Do not complete Item I-3-e.*
☐	**Yes**. **State or local government providers receive payment for waiver services.** *Complete item I-3-e.* Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish. *Complete item I-3-e.*
	State agency providers of behavioral health service, are eligible to provide all waiver services if they meet pertinent provider qualifications. All waiver services have open enrollment, and both public and private providers who are qualified can enroll.

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

☐	**The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
☒	**The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**

☒	**The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.** Describe the recoupment process:

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

☐	**Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
☒	**Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.** Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

☐	**No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
☒	**Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).** Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

☐	**No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
☒	**Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.** Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

☐	**The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
☒	**The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.** Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and (d) how payments are made to the health plans.
☒	**This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

APPENDIX I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

☐	**Appropriation of State Tax Revenues to the State Medicaid agency**
☐	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select one:*

☐	**Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
☐	**Applicable** *Check each that applies:*
☐	**Appropriation of Local Government Revenues.** Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:
☐	**Other Local Government Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds . *Select one:*

☐	**None of the specified sources of funds contribute to the non-federal share of computable waiver costs.**	
☒	**The following source(s) are used.** *Check each that applies.*	
	☐	**Health care-related taxes or fees**
	☐	**Provider-related donations**
	☐	**Federal funds**
	For each source of funds indicated above, describe the source of the funds in detail:	

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

☒	**No services under this waiver are furnished in residential settings other than the private residence of the individual.**
☐	**As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Respite service may be offered in a foster care home, provided the foster home meets all qualifications and is enrolled as a respite provider. Foster home room and board is paid with 100% State dollars. These funds are located in a separate account that can only be accessed through the use of appropriate edit codes.

APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.
Select one:

☐	**No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
☒	**Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.** The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

☐	**No. The State does not impose a co-payment or similar charge upon participants for waiver services.** (*Do not complete the remaining items; proceed to Item I-7-b*).
☒	**Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.** (*Complete the remaining items*)

i. Co-Pay Arrangement

Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

	Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*
☐	**Nominal deductible**
☐	**Coinsurance**
☐	**Co-Payment**
☐	**Other charge** *Specify*:

ii Participants Subject to Co-pay Charges for Waiver Services.

Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

iii. Amount of Co-Pay Charges for Waiver Services. The following table lists the waiver services defined in C-1/C-3 for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Charge	
	Amount	Basis

iv. Cumulative Maximum Charges.

Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

☐	**There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.**
☐	**There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.** Specify the cumulative maximum and the time period to which the maximum applies:

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

☐	**No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
☐	**Yes**. **The State imposes a premium, enrollment fee or similar cost-sharing arrangement.** Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income (c) the groups of participants subject to cost-sharing and the groups who are excluded; and (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care *(specify)*:	**Hospital as defined in 42 CFR §440.10** Psychiatric Care within a general hospital and inpatient psychiatric hospital for children/youths under age 21 as provided in 42 CFR 440.160.						
Col. 1	**Col. 2**	**Col. 3**	**Col. 4**	**Col. 5**	**Col. 6**	**Col. 7**	**Col. 8**
Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference (Column 7 less Column 4)**
1	$19,783	$45,710	$65,493	$11,941	$97,933	$109,874	$44,381
2	$20,648	$46,624	$67,273	$12,180	$99,892	$112,071	$44,799
3	$20,042	$47,557	$67,599	$12,423	$101,890	$114,313	$46,714
4	$20,173	$48,508	$68,681	$12,672	$103,927	$116,599	$47,918
5	$20,273	$49,478	$69,751	$12,925	$106,006	$118,931	$49,180

Appendix J-2: Derivation of Estimates

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
Year 1	240		
Year 2	290		
Year 3	360		
Year 4 (only appears if applicable based on Item 1-C)	420		
Year 5 (only appears if applicable based on Item 1-C)	480		

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-a.

280 days or 40 weeks – This is based upon the Average Length of Stay from the State's former CHANCE PRTF 1915(c) waiver.

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D was derived based on the fee schedule developed for services covered under this waiver, along with assumptions about number of users for each service, as well as the utilization for the average user of each service.

The utilization projections were based on experience in the CHANCE waiver that offered similar services, as well as experiences in other states' waiver programs when similar services were added to their array of waiver services:

- 100% of individuals are expected to receive case management services;
- Employment skills, career exploration and assessment and intensive supported employment services utilization are based upon estimates for a similar youth employment program in another state for children with disabilities as well as the CHANCE waiver for intensive supported employment;

- Respite utilization is based upon the historic South Carolina CHANCE waiver;
- The non-medical transportation utilization assumes a monthly payment to a transportation broker;
- CPST utilization is from the CHANCE Intensive Family Supports service utilization assumptions while the evidence-based practices utilization is from the expected utilization of these services in the underlying population.

Factor D estimates also reflect expected impacts of differences in the new PCSC waiver and the CHANCE waiver and other similar programs in other states with similar services and populations. Year 1 represents the baseline of the estimates for the Factor D (pricing using Master's rates only).

For Year 2 through Year 5, unit ~~costs~~ utilization was~~ere~~ trended forward using a 2.0% annual inflation factor, using the Mid-Atlantic Consumer Price Index (CPI) inflation factor for similar services from 2012 which the State believes is representative of the projected time periods in the waiver. http://www.bls.gov/regions/mid-atlantic/data/consumerpriceindexhistorical1967base_us_table.htm

After the adjustments were made and ~~service costs~~utilization determined for each waiver year, the projected Factor D was derived by dividing total service costs each year by the total estimated unduplicated count of waiver participants, as listed in Appendix B-2. The Average Length of State of the CHANCE waiver was utilized.

ii. Factor D′ Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is derived from projecting forward the Factor D' costs used in terminated South Carolina's CHANCE waiver. Costs are projected based on inflation of 2%, which is consistent with available mid-Atlantic CPI estimates that will be applicable to the time period as noted above. This children's population includes only Medicaid coverable costs and excludes the costs of prescribed drugs for individuals eligible for Medicare Part D.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is derived from state fiscal year (SFY) 2015 costs related to children with an inpatient admission to a standalone psychiatric hospital with a behavioral health diagnosis. The costs encapsulated in Factor G are for the inpatient costs. Costs are projected based on inflation of 2%, which is consistent with available mid-Atlantic CPI estimates that will be applicable to the time period as noted above. This children's population includes only Medicaid coverable costs and excludes the costs of prescribed drugs for individuals eligible for Medicare Part D.

iv. Factor G′ Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is derived from state fiscal year (SFY) 2015 costs related to children with an inpatient admission to a standalone psychiatric hospital with a behavioral health diagnosis. The costs encapsulated in Factor G' are for services other than the inpatient stay(s). G' is greater than D' because the G' includes the costs of stays in psychiatric residential treatment facilities (PRTFs) which can be longer term stays and cost. The costs encapsulated in Factor G are for the inpatient costs. Costs are projected based on inflation of 2%, which is consistent with available mid-Atlantic CPI estimates that will be applicable to the time period as noted above.

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
High Fidelity Wrap Around	manage components
Employment Skills Development	manage components
Career Exploration and Assessment	manage components
Intensive Supported Employment	manage components
Respite	manage components
Individualized Goods and Services	manage components
Non-Medical Transportation	manage components
Community Psychiatric Support and Treatment	manage components
Multi-Systemic Therapy (MST)	manage components
Functional Family Therapy (FFT)	manage components
Dialectical Behavior Therapy (DBT)	manage components
Homebuilders (HB)	manage components
Adolescent Community Reinforcement Approach (A-CRA)	manage components

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

☐	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
☒	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
High Fidelity Wraparound	Per Month	200	12	$1,072.70	$2,574,480
Employment Skills Development	15 min	10	506	$12.91	$65,325
Career Exploration and Assessment	15 min	4	656	$12.91	$33,876
Intensive Supported Employment	15 min	2	396	$20.21	$16,006
Respite	15 min	152	275	$7.18	$300,323
Respite	per diem	152	14	$114.96	$244,627
Individualized Goods and Services	per service	152	1	$2,000.00	$304,000
Non-Medical Transportation	Per Month	120	12	$140.00	$201,600
Community Psychiatric Support and Treatment (CPST)	15 min (individual)	152	260	$17.50	$691,452
CPST	15 min (group)	152	80	$3.29	$40,035
CPST - MST	15 min	7	320	$37.32	$83,588
CPST - FFT	15 min	1	89	$27.33	$2,432
CPST - DBT	15 min (individual)	10	208	$23.58	$49,037
CPST - DBT	15 min (group)	10	624	$7.86	$49,046
CPST - HB	15 min	10	250	$22.07	$55,169
CPST - A-CRA	15 min	20	56	$33.01	$36,968
GRAND TOTAL:					$4,747,964
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					240
FACTOR D (Divide grand total by number of participants)					$19,783
AVERAGE LENGTH OF STAY ON THE WAIVER					280 days

Waiver Year: Year 2					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
High Fidelity Wrap Around	Per Month	250	12	$1,072.70	$3,218,100
Employment Skills Development	15 min	13	516	$12.91	$86,600
Career Exploration and Assessment	15 min	5	669	$12.91	$43,184
Intensive Supported Employment	15 min	3	404	$20.21	$24,495
Respite	15 min	190	281	$7.18	$383,340
Respite	per diem	190	14	$114.96	$305,794
Individualized Goods and Services	per service	190	1	$2,000.00	$380,000
Non-Medical Transportation	Per Month	150	12	$140.00	$252,000
Community Psychiatric Support and Treatment (CPST)	15 min (individual)	190	265	$17.50	$881,125
CPST	15 min (group)	190	82	$3.29	$51,258
CPST - MST	15 min	9	326	$37.32	$109,497
CPST - FFT	15 min	1	91	$27.33	$2,487
CPST - DBT	15 min (individual)	13	212	$23.58	$64,986
CPST - DBT	15 min (group)	13	636	$7.86	$64,986
CPST - HB	15 min	13	255	$22.07	$73,162
CPST - A-CRA	15 min	25	57	$33.01	$47,039
GRAND TOTAL:					$5,988,054
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					290
FACTOR D (Divide grand total by number of participants)					$20,648
AVERAGE LENGTH OF STAY ON THE WAIVER					280 days

Waiver Year: Year 3					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
High Fidelity Wrap Around	Per Month	300	12	$1,072.70	$3,861,720
Employment Skills Development	15 min	15	526	$12.91	$101,860
Career Exploration and Assessment	15 min	6	682	$12.91	$52,828
Intensive Supported Employment	15 min	3	412	$20.21	$24,980
Respite	15 min	228	287	$7.18	$469,830
Respite	per diem	228	14	$114.96	$366,952
Individualized Goods and Services	per service	228	1	$2,000.00	$456,000
Non-Medical Transportation	Per Month	180	12	$140.00	$302,400
Community Psychiatric Support and Treatment (CPST)	15 min (individual)	228	270	$17.50	$1,077,300
CPST	15 min (group)	228	84	$3.29	$63,010
CPST - MST	15 min	11	333	$37.32	$136,703
CPST - FFT	15 min	2	93	$27.33	$5,083
CPST - DBT	15 min (individual)	15	216	$23.58	$76,399
CPST - DBT	15 min (group)	15	649	$7.86	$76,517
CPST - HB	15 min	15	260	$22.07	$86,073
CPST - A-CRA	15 min	30	58	$33.01	$57,437
GRAND TOTAL:					$7,215,093
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					360
FACTOR D (Divide grand total by number of participants)					$20,042
AVERAGE LENGTH OF STAY ON THE WAIVER					280 days

Waiver Year: Year 4 *(only appears if applicable based on Item 1-C)*					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
High Fidelity Wrap Around	Per Month	350	12	$1,072.70	$4,505,340
Employment Skills Development	15 min	18	537	$12.91	$124,788
Career Exploration and Assessment	15 min	7	696	$12.91	$62,898
Intensive Supported Employment	15 min	4	420	$20.21	$33,953
Respite	15 min	266	293	$7.18	$559,595
Respite	per diem	266	14	$114.96	$428,111
Individualized Goods and Services	per service	266	1	$2,000.00	$532,000
Non-Medical Transportation	Per Month	210	12	$140.00	$352,800
Community Psychiatric Support and Treatment (CPST)	15 min (individual)	266	275	$17.50	$1,280,125
CPST	15 min (group)	266	86	$3.29	$75,262
CPST - MST	15 min	12	340	$37.32	$152,266
CPST - FFT	15 min	2	95	$27.33	$5,193
CPST - DBT	15 min (individual)	18	220	$23.58	$93,377
CPST - DBT	15 min (group)	18	662	$7.86	$93,660
CPST - HB	15 min	18	265	$22.07	$105,274
CPST - A-CRA	15 min	35	59	$33.01	$68,166
GRAND TOTAL:					$8,472,806
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					420
FACTOR D (Divide grand total by number of participants)					$20,173
AVERAGE LENGTH OF STAY ON THE WAIVER					280 days

Waiver Year: Year 5 *(only appears if applicable based on Item 1-C)*					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
High Fidelity Wrap Around	Per Month	400	12	$1,072.70	$5,148,960
Employment Skills Development	15 min	20	548	$12.91	$141,494
Career Exploration and Assessment	15 min	8	710	$12.91	$73,329
Intensive Supported Employment	15 min	4	428	$20.21	$34,600
Respite	15 min	304	299	$7.18	$652,633
Respite	per diem	304	14	$114.96	$489,270
Individualized Goods and Services	per service	304	1	$2,000.00	$608,000
Non-Medical Transportation	Per Month	240	12	$140.00	$403,200
Community Psychiatric Support and Treatment (CPST)	15 min (individual)	304	281	$17.50	$1,494,920
CPST	15 min (group)	304	88	$3.29	$88,014
CPST - MST	15 min	14	347	$37.32	$181,301
CPST - FFT	15 min	2	97	$27.33	$5,302
CPST - DBT	15 min (individual)	20	224	$23.58	$105,638
CPST - DBT	15 min (group)	20	675	$7.86	$106,110
CPST - HB	15 min	20	270	$22.07	$119,178
CPST - A-CRA	15 min	40	60	$33.01	$79,224
GRAND TOTAL:					$9,731,172
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					480
FACTOR D (Divide grand total by number of participants)					$20,273
AVERAGE LENGTH OF STAY ON THE WAIVER					280 days

ii. Estimate of Factor D – Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1						
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
	☐					
	☐					
	☐					
	☐					
	☐					
	☐					
	☐					
	☐					
	☐					
	☐					
	☐					
	☐					
	☐					
	☐					
	☐					
	☐					
	☐					
GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 2						
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 3						
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 4 (only appears if applicable based on Item 1-C)						
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 5 (only appears if applicable based on Item 1-C)						
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
	⌐					
GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Application for

Section 1915(b) (4) Waiver
Fee-for-Service
Selective Contracting Program

v1.0

Table of Contents

Application for Section 1915(b) (4) Waiver
Fee-for-Service (FFS) Selective Contracting Program

Face Sheet

The **State** of _South Carolina _ requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is _Coordinated System of Care__.
(List each program name if the waiver authorizes more than one program.).

Type of request. This is:
_X__ an initial request for new waiver. All sections are filled.
___ a request to amend an existing waiver, which modifies Section/Part ____
___ a renewal request

Section A is:
- ___ replaced in full
- ___ carried over with no changes
- ___ changes noted in **BOLD**.

Section B is:
- ___ replaced in full
- ___ changes noted in **BOLD**.

Effective Dates: This waiver/renewal/amendment is requested for a period of _5__ years beginning **__08/01/2017__**and ending **__07/31/2022__**.

State Contact: The State contact person for this waiver is _Gwynne Goodlett _ and can be reached by telephone at (803) 605-2803, or fax at (803) 255-8204, or e-mail at _Gwynne.Goodlett@scdhhs.gov_.

Section A – Waiver Program Description

Part I: Program Overview

Tribal Consultation:
Describe the efforts the State has made to ensure that Federally-recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

There is one Federally-recognized tribe in South Carolina. South Carolina Department of Health and Human Services (SCDHHS) has shared a copy of the waiver proposal with them for input as part of our public input process. They were given 60-days to provide input.[Insert additional language if they provided any input/what was done with that input or whether no input was received].

Program Description:
Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver.

The State of South Carolina (State) is developing the Palmetto Coordinated System of Care (PCSC) for South Carolina's children and youth with significant behavioral health (BH) challenges or co-occurring conditions in or at imminent risk of out-of-home placement. PCSC is an evidenced-based approach that is part of a national movement to develop family-driven and youth-guided care, and keep children at home, in school, and out of the child welfare and juvenile justice systems. The State's goal is for children and families to receive services when needed and designed to achieve safe, healthy, and functional lives as successful, responsible, and productive citizens.

The purpose of 1915(c) waiver is to provide home and community-based supports and services to children with mental illness who would otherwise be served in inpatient general and psychiatric hospitals. Families and youths are offered the choice of behavioral health services and supports to permit the youths to remain in, or return to, the least restrictive environment-preferably their homes. To be eligible, a potential waiver child/youth must meet the inpatient level of care and meet all Medicaid financial requirements.

SCDHHS seeks to selectively contract with High Fidelity Wraparound facilitators and the statewide transportation entity to provide Non-medical Transportation services. Based on national research for children's system of care, SCDHHS will only contract with High Fidelity Wraparound providers credentialed by a national accrediting body. This is a qualification which is outlined in the service definition and for which selective contracting will be required. For Non-medical Transportation, the selective contracting is necessary to purchase services only from the statewide transportation entity to provide transportation, as specified by the person-centered plan, to enable children/youths to gain access to authorized home and community based services that enable them to integrate more fully into the community and ensure the health, welfare, and safety of the child/youth.

The following chart provides an estimate of the number of children projected to be served for each year of the program.

Annual Period	From	To	Projected Number of Participants
Year 1	August 1, 2017	July 31, 2018	240
Year 2	August 1, 2018	July 31, 2019	290
Year 3	August 1, 2019	July 31, 2020	360
Year 4	August 1, 2020	July 31, 2021	420
Year 5	August 1, 2021	July 31, 2022	480

The following services will be provided to the PCSC program participants:

- Non-Medical Transportation

Program details regarding non-medical transportation services are described in the PCSC 1915(c) waiver.

Waiver Services:
Please list all existing State Plan services the State will provide through this selective contracting waiver.

As noted above, this waiver seeks to selectively contract a transportation broker to provide non-medical transportation services to PCSC program participants. Given the size of the PCSC program and serving children with behavioral health needs, limiting the number of providers allows for greater program efficiencies.

A. Statutory Authority

1. **Waiver Authority.** The State is seeking authority under the following subsection of 1915(b):

   _X_ **1915(b) (4) - FFS Selective Contracting program**

2. **Sections Waived.** The State requests a waiver of these sections of 1902 of the Social Security Act:

a.___ **Section 1902(a) (1) - Statewideness**
b.___ **Section 1902(a) (10) (B) - Comparability of Services**
c._X__**Section 1902(a) (23) - Freedom of Choice**
d.___ **Other Sections of 1902** – (please specify)

B. Delivery Systems

1. **Reimbursement.** Payment for the selective contracting program is:

____ the same as stipulated in the State Plan
__X__ is different than stipulated in the State Plan (please describe)

High Fidelity Wraparound
SCDHHS will contract with only entities that meet the qualifications outlined in PCSC 1915(c) home and community-based waiver that a team must be credentialed by a national accrediting body as meeting the standards of High Fidelity Wraparound and demonstrate continued use of evidence-based wraparound standards as approved by SCDHHS through ongoing participation in wraparound fidelity monitoring. SCDHHS will not to accept any willing provider for this high intensity level of service.

Non-Medical Transportation
SCDHHS will contract with a single statewide transportation broker to provide non-medical transportation services. Reimbursement for transportation services will be on a fee-for-service (FFS) basis and cover the cost of providing all authorized transportation services plus an administrative fee for the broker's coordination functions.

2. **Procurement**. The State will select the contractor in the following manner:

___ **Competitive** procurement
___ **Open** cooperative procurement
___ **Sole source** procurement
_X__ **Other** (please describe)

High Fidelity Wraparound
High Fidelity Wraparound entities are required to be credentialed by a national accrediting body as meeting the standards of High Fidelity Wraparound and demonstrate continued use of evidence-based wraparound standards. The High Fidelity Entity must ensure on-going training of all child and family team members either through contract with national bodies or by employing nationally certified trainers. The High Fidelity entity must ensure that all child and family team members meet all conflict of interest requirements in the HCBS regulation.

Non-Medical Transportation
Currently SCDHHS contracts with a single statewide transportation broker to coordinate non-emergency medical transportation services under the State's Medicaid program.

SCDHHS will extend service delivery to include non-medical transportation services for the PCSC program, resulting in uniform, consistent approach to all Medicaid transportation services across the State.

C. Restriction of Freedom of Choice

1. **Provider Limitations**.

_X__ Beneficiaries will be limited to a single provider in their service area.
____ Beneficiaries will be given a choice of providers in their service area.

High Fidelity Wraparound
Participants will be given a choice of wraparound facilitators in their service area. However, because of the difficulty of obtaining and maintaining this certification, it is only expected that one or two providers at most will be available in the State of South Carolina. The program must guarantee the vendors enough volume of service to justify the vendors undergoing and maintaining the expense of the certification. It is expected that one vendor will serve children who are in DSS custody. The second vendor will serve children who are in their parent's or caregiver's custody. Participants will be given a choice of wraparound facilitators within each vendor.

SCDHHS will contract with High Fidelity Wraparound entities that are credentialed by a national accrediting body as meeting the standards of High Fidelity Wraparound and demonstrate continued use of evidence-based wraparound standards as approved by SCDHHS through ongoing participation in wraparound fidelity monitoring.

Non-Medical Transportation
SCDHHS will contract with a single statewide transportation broker to coordinate non-medical transportation services under the State's Medicaid program. Participants will be transported using the least costly, most appropriate transport. Participant requests for specific choice of provider may be granted based upon availability of the provider for a requested trip.

2. **State Standards**

Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents.

High Fidelity Wraparound
With the approval of the PCSC 1915(c) home and community-based waiver, High Fidelity Wraparound entity will be a new service covered through the waiver authority.

Non-Medical Transportation
The State Plan addresses coverage of non-emergency medical transportation for medical services. This waiver request is limited to non-medical transportation services under the HCBS PCSC program for children participating in the Coordinated System of Care 1915(c) waiver program. The child/youth's person-centered plan must document the need for those non-medical transportation services that are not covered under the medical

assistance transportation program. Additionally, reimbursement for non-medical transportation services will be on a FFS basis on a per-member, per-month basis (PMPM).

The transportation broker contract will specify the terms and conditions for service delivery. These standards will also apply to non-medical transportation services provided by the contractor. The contract is currently being modified to add additional requirements appropriate for HCBS participants, including but not limited to the following:

- The service is recommended by the wraparound facilitator and the child/youth in collaboration, and the service is included in the child/youth's person-centered plan; OR
- The service is directly related to a goal on the child/youth's person-centered plan related to community integration and/or employment;

AND the following criteria must be met:

- The service is needed to allow the child/youth the best opportunity to remain in the community, AND
- The child/youth has no other means of transportation available (e.g., family, neighbors, friends, carpools, co-workers, natural supports, community agencies); AND
- The service is not intended to meet the general transportation needs of the child/youth in an ongoing fashion; AND
- The service is not provided during the performance of the child/youth's paid employment; AND
- The frequency and intensity of the service aligns with the unique needs of the child/youth. Examples include:
    - A child/youth identifies the need for public transportation support to help her get to and from her new job she obtained through supported employment efforts.
    - A child/youth has established a goal to increase his social support network and needs non-medical transportation to a peer-operated program two days per week for the next three months.
- Non-medical Transportation does not pay for vehicle purchases, rentals, modifications, or repairs.

D. Populations Affected by Waiver

(May be modified as needed to fit the State's specific circumstances)

1. **<u>Included Populations</u>**. The following populations are included in the waiver:

___ Section 1931 Children and Related Populations
___ Section 1931 Adults and Related Populations
___ Blind/Disabled Adults and Related Populations
___ Blind/Disabled Children and Related Populations
___ Aged and Related Populations

___ Foster Care Children
___ Title XXI CHIP Children
_X_ Other
- Participants enrolled in the PCSC 1915(c) program

2. **Excluded Populations.** Indicate if any of the following populations are excluded from participating in the waiver:

___ Dual Eligibles
___ Poverty Level Pregnant Women
___ Individuals with other insurance
___ Individuals residing in a nursing facility or ICF/MR
___ Individuals enrolled in a managed care program
___ Individuals participating in a HCBS Waiver program
___ American Indians/Alaskan Natives
___ Special Needs Children (State Defined). Please provide this definition.
___ Individuals receiving retroactive eligibility
_X__Other (Please define):
- Any person who does not meet the targeting and needs-based criteria specified in the PCSC 1915(c) waiver.

Part II: Access, Provider Capacity and Utilization Standards

A. Timely Access Standards

Describe the standard that the State will adopt (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has adopted) defining timely Medicaid beneficiary access to the contracted services, *i.e.*, what constitutes timely access to the service?

1. How does the State measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program?

High Fidelity Wraparound

The following measures will be monitored as part of the state's HCBS assurances monitoring plan:

- *Number and percent of new enrollees who had an evaluation indicating the child/youth met LOC prior to receipt of services.*
- *Number and percent of Level of Care assessments completed within 365 days.*
- *Number and percent of children/youths with initial LOC determinations reviewed that were completed using the process required by the approved waiver.*

- *Proportion of children/youths whose plans were completed/revised prior to the provision of waiver services.*

- *Proportion of children/youths reviewed who received services in the type, scope, amount, duration and frequency specified in the person-centered plan.*

Non-Medical Transportation

The transportation broker contract specifies timeframes for non-urgent service delivery as well as pickup and delivery standards as follows:

- Non-urgent requests must be scheduled 3 days in advance.
- For transportation that involves an appointment for the participant, pickup must be made within 50 minutes before the scheduled pick up time and no later than 10 minutes past the scheduled pick up time. Drop off is up to 45 minutes prior to the appointment and no later than the appointment time.
- For otherwise scheduled transportation, pick up must be within 30 minutes of the scheduled pick up time OR within one hour of the call requesting pick up for open return times. Participants must be dropped off at their home destination as early as possible and within the normal drive time plus one hour.

The transportation broker must take into consideration the current level of mobility and functional independence of the participant in determining the most appropriate mode of transportation needed by the participant. This information is captured by the wraparound facilitator during the assessment of needs process and passed along to the transportation broker along with other relevant information regarding the frequency, scope and duration of transportation services.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion.

High Fidelity Wraparound

SCDHHS staff conduct performance reviews on providers to ensure that administrative functions are being carried out as required. If concerns are found with administrative functions, SCDHHS notifies the provider and requests a plan of correction. SCDHHS provides additional oversight in areas of concern until the provider has completed a plan of correction and demonstrated appropriate administrative performance.

When issues/problems/concerns are discovered by SCDHHS through formal quality review processes, the responsible party is notified by SCDHHS staff. SCDHHS staff identifies the problem, makes the responsible party aware of the problem and ensures that they have appropriate information to correct the problem. SCDHHS staff formally issues a statement of deficiency requiring a corrective action plan (CAP). If SCDHHS deems the problem/issue/concern to cause imminent danger to the waiver operations or children/youths, SCDHHS notifies the responsible party and the responsible party is restricted from conducting waiver related supports and services until the issues are resolved and SCDHHS accepts the CAP. Once written notification

is received, the CAP must be submitted within 30 days to SCDHHS. The corrective action plan addresses both immediate problems and identifies how the problems will be avoided in the future. SCDHHS reviews corrective action plans to ensure that they address the underlying issues/concerns. Failure to submit and implement a corrective action plan may result in being excluded from Medicaid.

When issues/problems/concerns are discovered by SCDHHS through informal processes, the responsible party is contacted by SCDHHS staff. SCDHHS staff identifies the problem, makes the responsible party aware of the problem and ensures that they have appropriate information to correct the problem. If SCDHHS deems the problem/issue/concern to cause imminent danger to the waiver operations or children/youths, SCDHHS ensures that immediate action is taken to protect the health and welfare of the child/youth, issues a formal notice of deficiency, and notifies the responsible party. If the issue/problem/concern is of a less serious nature, SCDHHS staff documents the contact and the request for correction to ensure that there is timely and appropriate follow up. The responsible party is given an opportunity to correct the problem informally and submit corrections to SCDHHS staff. If the problem is not addressed in a timely way, SCDHHS staff formally issues a statement of deficiency requiring a corrective action plan. Once written notification is received, the CAP must be submitted within 30 days to SCDHHS. The corrective action plan addresses both immediate problems and identifies how the problems will be avoided in the future. SCDHHS reviews corrective action plans to ensure that they address the underlying issues/concerns. Failure to submit and implement a corrective action plan may result in being excluded from Medicaid.

Non-Medical Transportation

SCDHHS will bring to the transportation broker's attention any identified issues. A corrective action plan may be imposed for issues that cannot be addressed timely.

If the transportation broker fails to comply with on time performance measures, SCDHHS may impose liquidated damages in the amount of $500 per business day for each business day the transportation broker fails to achieve a participant pick up or drop off percentage greater than or equal to 95%. SCDHHS may also impose liquidated damages in the amount of $500 per business day for each business day the transportation broker fails to achieve an overall minimal ride time percentage greater than or equal to 99% of the total trips within the allowable ride time.

Ultimately, if the violations are considered egregious and persistent, the transportation broker contract may be terminated and a new contractor sought for service delivery.

B. Provider Capacity Standards

Describe how the State will ensure (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has ensured) that its

selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs.

1. Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per contractor for non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program.

   High Fidelity Wraparound

   Upon program go-live (August 1, 2017), one High Fidelity Wraparound entity, the Continuum of Care (COC), will be available to support the PCSC program initially with a second added as soon as the provider is able to obtain national accreditation. Taking into consideration the projected estimate of PCSC participants in the first year of program implementation and the tasks to be performed, we believe this initial provider capacity is sufficient and will allow for a maximum 1:8 HFW facilitators to participant ratio. There will be a need for another HFW entity that SCDHHS contracts with that specializes in children in the custody of DSS and a contractor will be added for that population as soon as it is available.

   Non-Medical Transportation

   Annually, the transportation broker must demonstrate that the transportation provider network provides adequate access to services in each designated area in the State, based on the number of participants requesting and utilizing trips. If the contractor or SCDHHS identifies insufficient transportation resources in any area, the transportation broker shall, within five business days, develop and implement at transportation provider recruitment plan to meet the transportation needs of the participants in the geographical areas covered. During this interim period, transportation services shall still be delivered utilizing alternate resources. The transportation broker shall develop contingency plans in the event of unexpected changes with contracted transportation providers.

   The transportation broker must assure that non-medical transportation services are provided which comply with the following minimum service delivery requirements. These requirements must also be delineated in all transportation service agreements: On time arrival for scheduled pick-up shall be a standard practice. The transportation broker contract specifies timeframes for non-urgent service delivery as well as pickup and delivery standards as follows:

   - Non-urgent requests must be scheduled 3 days in advance.
   - For transportation that involves an appointment for the participant, pickup must be made within 50 minutes before the scheduled pick up time and no later than 10 minutes past the scheduled pick up time. Drop off is up to 45 minutes prior to the appointment and no later than the appointment time.
   - For otherwise scheduled transportation, pick up must be within 30 minutes of the scheduled pick up time OR within one hour of the call requesting pick up for open return times. Participants must be dropped off at their home

destination as early as possible and within the normal drive time plus one hour.

2. Describe how the State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions covered by the selective contracting program so that Medicaid beneficiaries have sufficient and timely access throughout the regions affected by the program.

High Fidelity Wraparound

SCDHHS will monitor the adequacy of HFW capacity through the HCBS assurance performance measures:

- *Proportion of children/youths reviewed who received services in the type, scope, amount, duration and frequency specified in the person-centered plan.*
- *Proportion of person-centered plans reviewed that were updated when the child/youth's needs changed.*
- *Proportion of children/youths whose plans were completed/revised prior to the provision of waiver services.*
- *Proportion of HFW providers that meet training requirements in the waiver*
- *Number and percent of HFW providers that continue to meet HCBS enrollment requirements.*
- *Number and percent of HFW providers that meet initial enrollment requirements prior to providing waiver services*

Non-Medical Transportation

At requested intervals, the transportation broker must report to SCDHHS regarding contracted transportation provider network capacity to support Medicaid, such as the number of contracted transportation providers and type, the number of credentialed vehicles and the number of seats available versus the actual utilization.

The transportation broker must also maintain contracted transportation provider records. Failure to do so will result in liquidated damages in the amount of $500 per occurrence for each occurrence where the transportation broker fails to establish and maintain records and related information in its file for each of its contracted transportation providers. This information can be analyzed to determine the adequacy of provider availability in all areas of the state.

C. Utilization Standards

Describe the State's utilization standards specific to the selective contracting program.

1. How will the State (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State) regularly monitor(s) the selective contracting program to determine appropriate Medicaid beneficiary utilization, as defined by the utilization standard described above?

High Fidelity Wraparound

SCDHHS believes that the availability of the HFW benefit will assist PCSC participants in gaining access to needed services and supports. SCDHHS will review service utilization and performance, as well as utilization as part of its ongoing monitoring functions through the HCBS assurances:

- *Number and percent of children/youths whose person-centered plans address their assessed needs, including health and safety risk factors, and personal goals.*
- *Proportion of children/youths whose plans were completed/revised prior to the provision of waiver services.*
- *Number and percent of claims paid for children/youths who were enrolled in the HCBS waiver program on the date of services.*

Non-Medical Transportation

At requested intervals, the transportation broker will submit accurate and complete management reports including trips by level of service, on time performance measures and ride time performance measures; the number of unduplicated participants and the total number of miles, broken out by mode of transportation service provided. Miles reported will represent miles as calculated by the transportation broker's point to point trip mapping program; detailed listing of "no shows"; number of trips assigned, cancelled, and re-routed by transportation provider; and number of trips that were multi-loaded.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above.

High Fidelity Wraparound

SCDHHS staff conduct performance reviews on providers to ensure that administrative functions are being carried out as required. If concerns are found with administrative functions, SCDHHS notifies the provider and requests a plan of correction. SCDHHS provides additional oversight in areas of concern until the provider has completed a plan of correction and demonstrated appropriate administrative performance.

When issues/problems/concerns are discovered by SCDHHS through formal quality review processes, the responsible party is notified by SCDHHS staff. SCDHHS staff identifies the problem, makes the responsible party aware of the problem and ensures that they have appropriate information to correct the problem. SCDHHS staff formally issues a statement of deficiency requiring a corrective action plan (CAP). If SCDHHS deems the problem/issue/concern to cause imminent danger to the waiver operations or children/youths, SCDHHS notifies the responsible party and the responsible party is restricted from conducting waiver related supports and services until the issues are resolved and SCDHHS accepts the CAP. Once written notification is received, the CAP must be submitted within 30 days to SCDHHS. The corrective action plan addresses both immediate problems and identifies how the problems will be avoided in the future. SCDHHS reviews corrective action plans to ensure that they

address the underlying issues/concerns. Failure to submit and implement a corrective action plan may result in being excluded from Medicaid.

When issues/problems/concerns are discovered by SCDHHS through informal processes, the responsible party is contacted by SCDHHS staff. SCDHHS staff identifies the problem, makes the responsible party aware of the problem and ensures that they have appropriate information to correct the problem. If SCDHHS deems the problem/issue/concern to cause imminent danger to the waiver operations or children/youths, SCDHHS ensures that immediate action is taken to protect the health and welfare of the child/youth, issues a formal notice of deficiency, and notifies the responsible party. If the issue/problem/concern is of a less serious nature, SCDHHS staff documents the contact and the request for correction to ensure that there is timely and appropriate follow up. The responsible party is given an opportunity to correct the problem informally and submit corrections to SCDHHS staff. If the problem is not addressed in a timely way, SCDHHS staff formally issues a statement of deficiency requiring a corrective action plan. Once written notification is received, the CAP must be submitted within 30 days to SCDHHS. The corrective action plan addresses both immediate problems and identifies how the problems will be avoided in the future. SCDHHS reviews corrective action plans to ensure that they address the underlying issues/concerns. Failure to submit and implement a corrective action plan may result in being excluded from Medicaid.

Non-Medical Transportation

SCDHHS will bring to the transportation broker's attention any identified issues. A corrective action plan may be imposed for issues that cannot be addressed timely.

If the transportation broker fails to comply with any of the requirements of the contract, SCDHHS may impose liquidated damages listed above. Ultimately, if the violations are considered egregious and persistent, the transportation broker contract may be terminated and a new contractor sought for service delivery.

Part III: Quality

A. Quality Standards and Contract Monitoring

1. Describe the State's quality measurement standards specific to the selective contracting program.

   a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

      i. Regularly monitor(s) the contracted providers to determine compliance with the State's quality standards for the selective contracting program.

<u>High Fidelity Wraparound</u>

A strong HFW benefit will be critical to the success of PCSC. As a result, several quality standards will be implemented to determine the effectiveness of the benefit, including but not limited to:

- *Proportion of HFW providers that meet training requirements in the waiver*
- *Number and percent of HFW providers that continue to meet HCBS enrollment requirements.*
- *Number and percent of HFW providers that meet initial enrollment requirements prior to providing waiver services*

- Performance measures that address the important functions performed by HFW facilitators such as:
  - *Proportion of participants notified of their rights to choose among waiver services and/or providers.*
  - *Number and percent of HCBS participants who received physical exams consistent with State of South Carolina 1915(c) program HCBS policy.*
  - *Number and percent of participants identified as needing medication admin and having a medication admin plan (Identified participants with Med admin plan/total reviewed records with med admin identified)*

<u>Non-Medical Transportation</u>

In addition to the utilization reports noted previously, several additional requirements are specified in the existing transportation broker contract that enables SCDHHS to monitor the quality and performance of the service delivery. This includes the transportation broker developing and maintaining a quality assurance plan approved by SCDHHS that at a minimum includes the following elements:

- Key indicators of quality related to scheduling and delivery of transportation services;
- A description of how the transportation broker plans to monitor these key indicators;

- A description of how the transportation broker will develop, implement, and evaluate corrective actions or modifications to overall operations as necessary to address quality concerns;
- A description of how the transportation broker will monitor the quality of transportation services;
- A description of the staffing resources responsible for the quality assurance plan and quality assurance activities; and
- Samples of all reports related to quality assurance and performance monitoring, along with descriptions of their use and who is responsible for reviewing them.

The quality assurance plan will be reviewed annually and revisions shall be submitted to SCDHHS for approval 30 calendar days prior to implementation.

SCDHHS has the discretion to collect additional data that can be used to develop and widely distribute broker and transportation provider reports. The information to be collected includes, but is not limited to:

- number of trips provided by type of transportation/by designated area
- number of trips provided by transportation provider/by designated area,
- number of clients served/by designated area,
- number of requests for transportation denied by reason/by designated area,
- average number of phone calls received daily,
- average number of phone calls abandoned daily,
- average "on hold" time,
- percentage of pick-ups and deliveries completed on time, and
- number and type of complaints.

To ensure that the transportation broker's call center meets quality standards, in addition to the reporting outlined above, liquidated damages in the amount of $5000 per month, for each month the transportation broker fails to answer 80% of all calls answered within 30 seconds, excluding the initial announcement; or for each month the average number of calls abandoned is greater than or equal to 5%; or for each month the average time for calls placed on hold exceeds 3 minutes.

ii. Take(s) corrective action if there is a failure to comply.

High Fidelity Wraparound

As noted previously, SCDHHS has several tools available to address a HFW entity's failure to comply with requirements. When issues are discovered by SCDHHS through formal quality review processes, the responsible party is notified by SCDHHS staff. SCDHHS staff identifies the problem, makes the responsible party aware of the problem and ensures that they have appropriate information to correct the problem. SCDHHS staff formally issues a statement of deficiency requiring a corrective action plan (CAP). If SCDHHS deems the issue to cause imminent danger to the waiver operations or children/youths, SCDHHS notifies the responsible party and the responsible party is restricted from conducting waiver related supports and services until the issues are resolved and SCDHHS accepts the CAP. Once written notification is received, the CAP must be submitted within 30 days to SCDHHS. The corrective action plan addresses both immediate problems and identifies how

the problems will be avoided in the future. SCDHHS reviews corrective action plans to ensure that they address the underlying concerns. Failure to submit and implement a corrective action plan may result in being excluded from Medicaid.

When issues are discovered by SCDHHS through informal processes, the responsible party is contacted by SCDHHS staff. SCDHHS staff identifies the problem, makes the responsible party aware of the problem and ensures that they have appropriate information to correct the problem. If SCDHHS deems the issue to cause imminent danger to the waiver operations or children/youths, SCDHHS ensures that immediate action is taken to protect the health and welfare of the child/youth, issues a formal notice of deficiency, and notifies the responsible party. If the issue is of a less serious nature, SCDHHS staff documents the contact and the request for correction to ensure that there is timely and appropriate follow up. The responsible party is given an opportunity to correct the problem informally and submit corrections to SCDHHS staff. If the problem is not addressed in a timely way, SCDHHS staff formally issues a statement of deficiency requiring a corrective action plan. Once written notification is received, the CAP must be submitted within 30 days to SCDHHS. The corrective action plan addresses both immediate problems and identifies how the problems will be avoided in the future. SCDHHS reviews corrective action plans to ensure that they address the underlying issues/concerns. Failure to submit and implement a corrective action plan may result in being excluded from Medicaid.

Non-Medical Transportation

As noted previously, SCDHHS has several tools available to address a transportation broker's failure to comply with requirements. The tools include the following.

- SCDHHS will bring to the transportation broker's attention any identified issues. A corrective action plan may be imposed for issues that cannot be addressed timely.
- If the transportation broker fails to comply with any of the requirements of the contract, SCDHHS may impose liquidated damages outlined above.
- Ultimately, if the violations are considered egregious and persistent, the transportation broker contract may be terminated and a new contractor sought for service delivery.

2. Describe the State's contract monitoring process specific to the selective contracting program.

    a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

        i. Regularly monitor(s) the contracted providers to determine compliance with the contractual requirements of the selective contracting program.

High Fidelity Wraparound

SCDHHS staff conduct performance reviews on providers to ensure that administrative functions are being carried out as required. If concerns are found with administrative functions, SCDHHS notifies the provider and requests a plan of correction. SCDHHS provides additional oversight in areas of concern until the provider has completed a plan of correction and demonstrated appropriate administrative performance.

Non-Medical Transportation

In addition to the monitoring requirements noted above, the transportation broker contract requires SCDHHS to monitor:

- Staffing levels, including drivers and their training, which may include announced and unannounced visits to observe driver training programs,
- Review inspection of vehicle and maintenance reports,
- Inspect driver records to ensure that proper training has been provided
- Announced and unannounced visits to ensure compliance, and
- Complaint reports.

ii. Take(s) corrective action if there is a failure to comply.

High Fidelity Wraparound

As noted previously, SCDHHS has several tools available in its tool kit to address a HFW entity's failure to comply with requirements. When issues are discovered by SCDHHS through formal quality review processes, the responsible party is notified by SCDHHS staff. SCDHHS staff identifies the problem, makes the responsible party aware of the problem and ensures that they have appropriate information to correct the problem. SCDHHS staff formally issues a statement of deficiency requiring a corrective action plan (CAP). If SCDHHS deems the issue to cause imminent danger to the waiver operations or children/youths, SCDHHS notifies the responsible party and the responsible party is restricted from conducting waiver related supports and services until the issues are resolved and SCDHHS accepts the CAP. Once written notification is received, the CAP must be submitted within 30 days to SCDHHS. The corrective action plan addresses both immediate problems and identifies how the problems will be avoided in the future. SCDHHS reviews corrective action plans to ensure that they address the underlying concerns. Failure to submit and implement a corrective action plan may result in being excluded from Medicaid.

When issues are discovered by SCDHHS through informal processes, the responsible party is contacted by SCDHHS staff. SCDHHS staff identifies the problem, makes the responsible party aware of the problem and ensures that they have appropriate information to correct the problem. If SCDHHS deems the issue to cause imminent danger to the waiver operations or children/youths, SCDHHS ensures that immediate action is taken to protect the health and welfare of the child/youth, issues a formal notice of deficiency, and notifies the responsible party. If the issue is of a less serious nature, SCDHHS staff documents the contact and the request for correction to ensure that there is timely and appropriate follow up. The responsible party is given an opportunity to correct the problem informally and submit corrections to SCDHHS staff. If the problem is not addressed in a timely way, SCDHHS staff formally issues a statement of deficiency requiring a corrective action plan. Once written notification is received, the CAP must be submitted within 30 days to SCDHHS. The corrective action plan addresses both immediate problems and identifies how the problems will be avoided in the future. SCDHHS reviews corrective action plans to ensure that they address the underlying issues/concerns. Failure to submit and implement a corrective action plan may result in being excluded from Medicaid.

Non-Medical Transportation

As noted previously, SCDHHS has several tools available in its tool kit to address a transportation broker's failure to comply with requirements. The tools include the following:

- SCDHHS will bring to the transportation broker's attention any identified issues. A corrective action plan may be imposed for issues that cannot be addressed timely.
- If the transportation broker fails to comply with any of the requirements of the contract, SCDHHS may impose liquidated damages outlined above.
- Ultimately, if the violations are considered egregious and persistent, the transportation broker contract may be terminated and a new contractor sought for service delivery.

B. Coordination and Continuity of Care Standards

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program.

High Fidelity Wraparound

A workgroup with family, youth, provider, and state agency representatives spent several months developing a set of outcome measures including parent/caregiver satisfaction and administrative measures. In addition, High Fidelity Wraparound entities must meet ongoing evidence-based fidelity measures. These fidelity measures include, among other measures, quarterly administration of a survey to parents/caregivers and youth. The outcome measures will be used to determine the overall effectiveness of the PCSC waiver and the fidelity measures will be used to determine the effectiveness of High Fidelity Wraparound. Both measures will ensure that coordination and continuity of care is not negatively impacted by selective contracting.

Non-Medical Transportation

Wraparound facilitators will conduct regular and ongoing monitoring of the health and welfare of the children receiving non-medical transportation in accordance with the child's person-centered service plan. Therefore, wraparound facilitators will be the first line of defense in ensuring that selective contracting for transportation does not negatively impact the ability of children in the PCSC program to access needed services.

Part IV: Program Operations

A. Beneficiary Information

Describe how beneficiaries will get information about the selective contracting program.

Several resources will be used to provide information to families of children enrolled in the PCSC program regarding transportation services one it is identified as a need and documented within their person centered plan of care. Information regarding the PCSC program, including accessing services through the transportation broker will be included in written informational materials describing the program and available via the PCSC website. Additionally, as part of the assessment of need and plan of care development process, wraparound facilitators will provide information to families about transportation services and how to access services through the transportation broker, both verbally and in written format.

B. Individuals with Special Needs.

_X__ The State has special processes in place for persons with special needs (Please provide detail).

The PCSC program, by design, targets only children with special needs – those at risk for out of home placement without receiving the home and community-based services. Therefore, this waiver provides the special processes to support transportation services for eligible children. These children will also continue to maintain direct access to their comprehensive health care benefits provided under the State Plan including primary care providers and specialists, etc., as needed for their individual health care conditions.

Section B – Waiver Cost-Effectiveness & Efficiency

Efficient and economic provision of covered care and services:

1. Provide a description of the State's efficient and economic provision of covered care and services.

2. Project the waiver expenditures for the upcoming waiver period.

Year 1 from: __8/01/2017__ to _7/31/2018_

Trend rate from current expenditures (or historical figures): ___2_____%

High Fidelity Wraparound

Projected pre-waiver cost	$0
Projected Waiver cost	$2,574,480
Difference:	$2,574,480

Non-Medical Transportation

Projected pre-waiver cost	$0
Projected Waiver cost	$ 201,600
Difference:	$ 201,600

Year 2 from: _8/01/2018__ to _7/31/2019___

Trend rate from current expenditures (or historical figures): ___2_____%

High Fidelity Wraparound

Projected pre-waiver cost	$0
Projected Waiver cost	$3,218,100
Difference:	$3,218,100

Non-Medical Transportation

Projected pre-waiver cost	$0
Projected Waiver cost	$ 257,040
Difference:	$ 257,040

Year 3 (if applicable) from: _8/01/2019__ to 7/31/2020__
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Unit costs for years 3-5 were trended forward using a 2.0% annual inflation factor, using the Mid-Atlantic Consumer Price Index (CPI) inflation factor for similar services from 2012 which the State believes is representative of the projected time periods in the waiver.

http://www.bls.gov/regions/mid-atlantic/data/consumerpriceindexhistorical1967base_us_table.htm

High Fidelity Wraparound

Projected pre-waiver cost	$0
Projected Waiver cost	$3,861,720
Difference:	$3,861,720

Non-Medical Transportation

Projected pre-waiver cost	$0
Projected Waiver cost	$ 314,626
Difference:	$ 314,626

Year 4 (if applicable) from: _8/01/2020_ to 7/31/2021___
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

High Fidelity Wraparound

Projected pre-waiver cost	$0
Projected Waiver cost	$4,505,340
Difference:	$4,505,340

Non-Medical Transportation

Projected pre-waiver cost	$0
Projected Waiver cost	$ 374,396
Difference:	$ 374,396

Year 5 (if applicable) from: _8/01/2021__ to 7/31/2022___
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

High Fidelity Wraparound

Projected pre-waiver cost	$0
Projected Waiver cost	$5,148,960
Difference:	$5,148,960

Non-Medical Transportation

Projected pre-waiver cost	$0
Projected Waiver cost	$ 436,435
Difference:	$ 436,435